



**Faculty of Social Sciences and Humanities**

**Women with Mental Health Problems: A Study at a Care Centre in Perak,  
Malaysia**

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Women with Mental Health Problems: A Study at a Care Centre in Perak,  
Malaysia

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## **DECLARATION**

I, Yong Phooi Ling (16020005) from Faculty of Social Sciences and Humanities hereby declare that the work entitled, “Women with mental health problems: A study at a care centre in Perak, Malaysia” is my original work. I have not copied from any other students’ work or from any other sources except where due reference or acknowledgement is made explicitly in the text, nor has any part been written for me by another person. The thesis has not been accepted for any degree and is not concurrently submitted in candidature of any other degree.

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(Date submitted)

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## **ABSTRACT**

In Malaysia, according to the National Health and Morbidity Survey (NHMS, 2011), mental health problems are more prevalent amongst women than men. According to current research findings on mental health issues, women are more vulnerable than men to acquire particular mental health problems such as depression, bipolar disorder, and schizophrenia. Furthermore, women have a higher tendency than men to seek professional help. However, the experiences of the people with mental health problems especially women have not been well understood, and in fact very much neglected or ignored. This study aims to explore the experiences of women with mental health problems on their admission and at the care centre. This study employs a qualitative research method through face-to-face in-depth interview guided by an interview guide and feminist perspective in understanding women's health care practices. The findings are analysed using thematic analysis to extract emergent themes from the verbatim data. The main themes derived from the findings include experiences before and after admission. The results show that the admission to the centre provides both positive and negative experiences to the participants. Majority of participants were unwillingly admitted to the centre. However, the admission to the centre helped participants to improve their relationship with family members, and formed new and good relationship with other residents and the care centre staffs. Nevertheless, participants revealed that they sometimes experienced 'oppression' by the staffs and the medical practitioners. In addition, majority of the participants in this research more preferred to live at home with family members if they were given the choice. The findings of the study have implications on the social work practice with women with mental health problems in improving the health care policy and health care services.

**Keywords:** Women, mental health, mental health problems, admission, care centre

***Wanita dengan Masalah Kesihatan Mental: Satu Kajian di Pusat Penjagaan di Perak, Malaysia***

***ABSTRAK***

*Di Malaysia, menurut Tinjauan Kesihatan dan Morbiti Kebangsaan (NHMS, 2011), masalah kesihatan mental tersebar luas di kalangan kaum wanita daripada kaum lelaki. Menurut hasil kajian semasa atas isu-isu kesihatan mental, wanita adalah lebih terdedah daripada lelaki untuk memperoleh masalah kesihatan mental tertentu seperti kemurungan, penyakit bipolar, dan skizofrenia. Tambahan pula, wanita mempunyai kecenderungan lebih tinggi daripada lelaki untuk mendapat pertolongan profesional. Walau bagaimanapun, pengalaman individu dengan masalah kesihatan mental terutamanya wanita belum lagi difahami dengan baik, dan sebenarnya sangat diabaikan atau disisihkan. Kajian ini bertujuan untuk meneroka pengalaman wanita dengan masalah kesihatan mental atas kemasukan dan pengalaman mereka di dalam pusat penjagaan. Kajian ini menggunakan kaedah penyelidikan kualitatif melalui temu bual secara mendalam dengan menggunakan panduan temu bual dan perspektif feminis untuk memahami amalan penjagaan kesihatan wanita. Hasil kajian dianalisis dengan menggunakan analisis tematik untuk mengekstrak tema yang muncul diperolehi dari data verbatim. Tema-tema utama yang diperolehi daripada penemuan bual termasuk pengalaman sebelum dan selepas kemasukan. Hasil kajian menunjukkan bahawa kemasukan ke pusat penjagaan memberi pengalaman yang positif dan negatif kepada para responden. Majoriti responden adalah tidak rela untuk masuk ke pusat tersebut. Walau bagaimanapun, kemasukan ke pusat ini membantu responden memperbaiki dan mengeratkan hubungan mereka dengan ahli keluarga, dan membentuk hubungan yang baru dan baik dengan residen lain dan kakitangan pusat jagaan. Walau bagaimanapun responden mendedahkan bahawa mereka kadang kala mengalami “penindasan” oleh kakitangan dan pengamal perubatan. Di samping itu, majoriti*

*responden dalam kajian ini lebih suka untuk tinggal di rumah dengan ahli keluarga jika mereka diberi pilihan. Hasil kajian ini mempunyai implikasi terhadap amalan kerja sosial dengan wanita dengan masalah kesihatan mental dalam meningkatkan dasar dan perkhidmatan penjagaan kesihatan.*

**Kata kunci:** *Wanita, kesihatan mental, masalah kesihatan mental, kemasukan, pusat penjagaan*

## TABLE OF CONTENTS

	Page
<b>DECLARATION</b>	i
<b>ACKNOWLEDGEMENT</b>	ii
<b>ABSTRACT</b>	iii
<b><i>ABSTRAK</i></b>	iv
<b>TABLE OF CONTENTS</b>	vi
<b>LIST OF TABLES</b>	x
<b>LIST OF FIGURES</b>	xi
<b>LIST OF ABBREVIATIONS</b>	xii
 <b>CHAPTER 1: INTRODUCTION</b>	 1
1.1 Introduction	1
1.2 Background of the Study	2
1.3 Problem Statement	5
1.3.1 Personal Interest	7
1.4 Research Questions	8
1.5 Research Objectives	8
1.6 Significance of Study	8
1.7 Structure of Thesis	10
 <b>CHAPTER 2: LITERATURE REVIEW</b>	 11
2.1 Definitions of Mental Health and Mental Disorders	11
2.1.1 Classification of Common Mental Health Problems	14
2.2 Mental Health Concepts in Malaysia	18



2.3 Help-Seeking Behaviour	23
2.3.1 Mental Health Care Services in Other Countries	25
2.3.2 Mental Health Services from Colonization to Independence in Malaysia	29
2.4 Experiences of People with Mental Health Problems	33
2.5 Feminist Perspectives	42
2.5.1 Feminist Perspectives in Women's Health and Mental Health Care	47
2.6 Conclusion	49
<b>CHAPTER 3: RESEARCH METHODOLOGY</b>	<b>51</b>
3.1 Research Methodological Framework	51
3.2 Research Location	54
3.3 Research Participants	56
3.4 Data Collection Process	60
3.5 Data Transcription and Analysis	64
3.6 Ethical Consideration	69
3.7 Insider Perspectives	72
3.8 Validity and Reliability	74
3.9 Limitations	75
3.10 Conclusion	75
<b>CHAPTER 4: FINDINGS AND DISCUSSION</b>	<b>77</b>
4.1 Description of Participants	77
4.1.1 Age of Participants	77
4.1.2 Marital Status of Participants	78
4.1.3 Education Level of Participants	79

4.1.4 Religion Affiliation of Participants	80
4.1.5 Origins of Participants	80
4.1.6 Year Range of Staying at the Centre of Participants	81
4.1.7 Diagnosis of Participants	82
4.1.8 Brief Summary of Participants' Stories	82
4.2 Experiences Before Admission	87
4.2.1 Age Onset of Mental Health Problems	88
4.2.2 Help-Seeking Behaviour	90
4.2.3 Admission to Inpatient Care	92
4.2.4 Admission to the Care Centre	94
4.3 Living Experiences in the Centre	100
4.3.1 Relationship	102
4.3.2 "Oppressed" by the Centre Staffs and Medical Practitioners	108
4.3.3 Isolation and Separation	113
4.3.4 From Buddhism to Christianity	116
4.3.5 Satisfaction of Staying at the Centre	118
4.3.6 Preference of Living at Home	121
4.3.7 Self-Perception	123
4.4 Conclusion	131
<b>CHAPTER 5: CONCLUSION AND RECOMMENDATIONS</b>	135
5.1 Major Findings of the Study	135
5.2 Recommendations for Future Research	137
5.3 Implications to Social Work Practice	139
5.4 Conclusion	140

<b>REFERENCES</b>	143
<b>APPENDICES</b>	161

## LIST OF TABLES

	<b>Page</b>
Table 2.1      Classification of Mental Health Problems	16
Table 2.2      Scope of Services in the Malaysia Psychiatric and Mental Health Services Operational Policy	28
Table 2.3      Summary of Selected Review Studies on Stigmatization and Discrimination Experiences in Other Countries and in Malaysia	35
Table 2.4      Summary of Selected Review Studies on Experiences in Decision Making in Other Countries and in Malaysia	38
Table 2.5      Summary of Selected Reviewed Studies on Subjective Experiences in Other Countries and in Malaysia	41
Table 3.1      Participants' Social Demographic Background	59
Table 3.2      Example of Interview Excerpt of Koh_48_SZ	66
Table 4.1      Age Range of Participants	78
Table 4.2      Marital Status of Participants	79
Table 4.3      Education Level of Participants	79
Table 4.4      Religion Affiliation of Participants	80
Table 4.5      Origins of Participants	81
Table 4.6      Years Range of Staying at the Centre of Participants	81
Table 4.7      Diagnosis of Participants	82
Table 4.8      Brief Summary of Participants' Stories	83
Table 4.9      Experiences Before Admission	88
Table 4.10     Living Experiences in the Centre	101

## **LIST OF FIGURES**

		<b>Page</b>
Figure 2.1	Components of the Mental Health Services in Other Countries	26
Figure 2.2	Government Mental Health Services in Malaysia	30
Figure 2.3	Adapted Ecological Model and Feminist Perspectives	44
Figure 3.1	Example of Sample Selection Process	58
Figure 3.2	Example of Coding for Recorded Audio	64
Figure 3.3	Example of Translation and Back Translation Process	66
Figure 3.4	Example of Process of Developing Themes	68
Figure 4.1	The Pathways of Help-Seeking	90

## **LIST OF ABBREVIATIONS**

DSM	Diagnostic and Statistical Manual of Mental Disorders
ICD	International Classification of Disease
MOH	Ministry of Health
NHMS	National Health and Morbidity Survey
WHO	World Health Organization

# **CHAPTER 1**

## **INTRODUCTION**

This chapter lays out the foundation of the thesis. It introduces the study and then follows by the background of the study. It also outlines the problem statement, research questions, and research objectives. This is followed by the significance of the study. The last section of this chapter outlines the structure of this thesis.

### **1.1 Introduction**

Mental health problems<sup>1</sup> have been affecting the live and well-being of an individual (Cockerham, 2000) regardless of age, culture and socioeconomic levels (Borges et al., 2010) throughout the world. It is now becoming a serious issue in Malaysia because mental disorders were ranked fourth as the leading cause of diseases based on the 2000 Malaysia National Census (Sidik, Arroll, & Goodyear-Smith, 2012). Mental health problems were prevalent among Malaysian adults have showed an increase from 10.7% in 1996, to 11.2% in 2006, and to 29.2% in 2015 based on the Malaysia National Health and Morbidity Survey (NHMS)<sup>2</sup> (Institute for Public Health, 2015). However, fewer studies were conducted in Malaysia to research about the experiences of the people with mental health problems especially women who are receiving mental health care services at health care settings. Past

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<sup>1</sup> Throughout the study, the term “mental health problems” is being used because by adding the word “problems”, the term “mental health” can be connoted as a less stigmatize state and maybe less offensive to some parties (Pilgrim, 2009).

<sup>2</sup> The abbreviation for National Health and Morbidity Survey – NHMS will be used in the entire thesis. NHMS is a decennial survey done by the Institute for Public Health to provide community-based data and information on health to inform the Malaysia Ministry of Health in the health priorities, programme strategies, activities as well as the resources planning and allocation’s review (Institute for Public Health, 2015). The NHMS was started in 1986, NHMS II was then conducted in 1996, followed by the NHMS III in 2006. However, to ensure the efficacy of data and information, the interval was shortened from 10 to 4 years since 2011. The latest NHMS 2015 was conducted in 2015.

studies conducted in Malaysia are more focused on the evaluation of services provided (Low & Lee, 2015), experiences of psychological distress faced (Low, Lee, & Jacob, 2017), experiences of family and caretakers using community mental health services (Chang & Horrocks, 2006; Mohamad et al., 2011), and experiences in institutional care (Crabtree, 2004). Thus, this study aims to understand the experiences of women with mental health problems in a care centre in Perak, Malaysia.

## **1.2 Background of the Study**

According to NHMS, women showed greater prevalence of mental health problems than men (30.8% vs 27.6%) (Institute for Public Health, 2015). The World Health Organisation (WHO)<sup>3</sup> mentioned that differences in gender occurred in the mental health problems' prevalence rate was predominated by women and affecting 1 in 3 people in the community (2018). For example, a study carried out by Freeman's in the UK reported that 75% of women are more likely to have depression and 60% more likely to have an anxiety disorder compared to men (Ball, 2013). Depression is also twice as common in women (WHO, 2018). In Malaysia, based on the statistics available, mental health problems are also more prevalent amongst women (My Sinchew.com, 2009; Sidik, Arroll, & Goodyear-Smith, 2011). The rate of depression among women in Malaysia is double compared to men, and anxiety in women is 2 to 3 times higher than men (Malhotra & Shah, 2015). However, gender differences showed no significant in the severe mental health problems' rates such as schizophrenia and bipolar disorder (WHO, 2018). The Chinese population was found to have the highest occurrence of mental health problems at 31.1% among the entire ethnic group based on the third NHMS (Institute for Public Health, 2008), but it has decreased from 6.9% to 24.2% in 2015 based on the NHMS 2015 (Institute for Public Health, 2015).

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<sup>3</sup> The abbreviation for World Health Organisation – WHO will be used in the entire thesis.



Moreover, women are known to have greater extent to seek help from primary care physicians for their mental health problems than men (Zuraida, 2008). Gender differences showed in the help seeking patterns for mental health problems as pointed out by WHO (2018). Women were found to have higher tendencies to seek professional help (Matlin, 2012), outpatient services (Veroff et al., 1981 cited in Cockerham, 2000) and attending primary care (Zuraida, 2008), but men were more likely to be admitted to inpatient care such as mental hospitals (Centre for Mental Health Service, 1994c cited in Cockerham, 2000). This is probably because the female conditions are seen as less threatening to society as compared to men and thus allowing them to be treated on an outpatient basis (Cockerham, 2000). According to WHO (2018), women are more likely to reveal their mental health problems to a primary health care physician, but men are possibly to disclose their alcoholic problems to their health care provider.

In Malaysia, people with mental health problem<sup>4</sup> were commonly institutionalized in the 1960's and 1970's (Low & Lee, 2015) and later the institution became overcrowded with the growth of population because it was the only service available to the people with mental health problems until 1959 after the establishment of psychiatric units in general hospitals (Salleh, 1992). Later in the late 1990's, with the support of formulated mental health policy, legislation and framework, Malaysia mental health services have undergone a positive development from the traditional custodial care<sup>5</sup> in mental institutions towards community mental health care (Abdul Kadir Abdul Bakar, 2011).

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<sup>4</sup> The reason of using the term "people with mental health problems" because social work and social care practitioners uphold the "person-first" approach which promotes the person rather than the reasons a person becomes a service user (Penhale & Parker, 2008). The terms mental patient or mentally ill patient are avoided because they are stigmatizing.

<sup>5</sup> Custodial care is the non-skilled personal care with the daily life activities such as bathing, dressing, eating, moving around, getting in or out of bed, and using bathroom for someone who is unable to fully perform these activities (National Council on Aging, n.d.).

In 2001, the National Mental Health Act was introduced and supported by general hospitals and community clinics, people with mental health problems were discharged into the community and cared for by family members (Chong, Mohammed, & Er, 2013). Moreover, in line with the introduction of community psychiatric services and the decentralization movement of psychiatric services, primary care settings have become the first-line health service provider in Malaysia (Riana, Osman, & Ainsah, 2008). Based on Mental Health Atlas (2011), mental health care provision in Malaysia was integrated into primary care because majority of the primary health care doctors have gone through mental health in-service training and the officially approved mental health problems management and treatment manuals were available in most of the primary health care clinics. Therefore, individuals with mental health problems sometimes were referred from primary care to secondary or tertiary care and vice versa (Mental Health Atlas, 2011).

Though modern treatment for mental health problems is available locally, according to Ng (2007), Malaysians who suffer from mental health problems tend to seek traditional treatment first before formal psychiatric care. This is because Malaysian hold diverse mental health concepts (Perveen et al., 2017) and views on help-seeking pathways due to the multi religious and multiple ethnic groups that make up the Malaysian society (Lim, 2015), as well as diversified perception on the problems (Abdul Kadir & Bifulco, 2010). For example, belief in the supernatural, magical charms and witchcraft is common in the case of mental health problems among the Malaysian society and thus shamanistic and traditional healers such as the Malay *Bomoh*, or the Chinese mediums are popular among the people with mental health problems of all ethnic groups (Ling, 2007).

Therefore, people with mental health problems will seek medical services as the last resort after seeking help from traditional healers (Abdul Kadir & Bifulco, 2010). The people

with mental health problems especially women faced challenges when receiving mental health care services in health care facilities as the WHO discovered authoritarian communication happened between the health workers and women patients who suffering from psychological and emotional distress, has make the treatment more difficult and the patients to be stigmatized (WHO, 2018). Women also tend to experience gender biases such as over-treatment or are neglect by the health workers when disclosing their problems (WHO, 2018).

### **1.3 Problem Statement**

Previous studies conducted with people with mental health problems in western countries showed that they faced challenges in health care settings. For example, a study conducted by Owen et al. (1998) in the women-only residential rehabilitation house in Nottingham discovered that women with mental health problems have suffered a sense of loss in many cases throughout their lives, such as loss of material comfort and emotional support, as well as loss of control or choice in their lives. Another study conducted by Granerud and Severinsson (2003) in Norway showed that people with mental health problems had less contact with their neighbours, experienced lack of acceptance and loss of autonomy when reside in a group home. A past study conducted by Manuel et al. (2011) in New York found that women with mental health problems faced several barriers such as fear of insufficient treatment support, social isolation, concerns on safety, stigma and lack of resources to meet daily needs when transited from psychiatric hospital care to the community.

However, mental health researches in Malaysia have a different focus. Past studies conducted in Malaysia explored the living experiences of the family caregivers of people with mental health problems (Chang & Horrocks, 2006), the experiences of stigma and discrimination of mental illness from the perspectives of mental health professionals

(Hanafiah & Bortel, 2015) and a study conducted by Lim (2015) on reducing stigma towards people with mental health problems. According to Liamputtong (2009), women and the mentally ill are among the vulnerable groups because they are often hard to reach, the hidden, the deviant, the tabooed and thus they are the invisible populations in society. Hence, lack of opportunity to voice their concerns, fear of being disrespect because of their identities, the stigma attached to their social conditions are some of the reasons for the invisibility of the vulnerable groups (Liamputtong, 2009). Therefore, it is important to conduct research with the marginalised groups to discover the facts of their lives and experiences (Liamputtong, 2009).

In Malaysia, there is a need to further explore the experiences of women after they are in the health care system. Moreover, the experiences of people with mental health especially women in the care settings in Malaysia are often neglected and remain unexplored since other study explored the experiences of female psychiatric patients in institutional care in Malaysia (Crabtree, 2004). Past studies in Malaysia also focused more on the experiences of people with mental health problems as a service user such as the patient involvement in healthcare decision-making from the perspective of professional medical practitioners (Ng et al., 2013), the experiences in receiving service provided (Low & Lee, 2015), and the experiences of psychological distress faced by them (Low, Lee, & Jacob, 2017).

Although the two studies conducted by Low and Lee (2015), and Low, Lee and Jacob (2017) with the residents in a community-based rehabilitation centre in Malaysia, the studies focused on exploring the experiences of the service users towards the service provided and their psychological distress faced rather than their living experiences in the care setting. Acknowledging this gap, this study aims to explore the experiences of women with mental health problems in a care centre in Perak, Malaysia. The study focuses on the experiences of

the women with mental health problems in a care centre in Malaysia by using qualitative research method because it allows the researched to express their feelings and experiences in their own words and perspectives (Liamputtong, 2009).

### **1.3.1 Personal Interest**

The interest of studying *Women with mental health problems: A study at a care centre in Perak, Malaysia* began during my industrial training at this centre as a social work student from July to September in the year 2015. A few women in the centre shared with me interesting stories about themselves on admission experiences, their background, and family relationships. Some of them were very enthusiastic and passionate in sharing about their experiences in the centre. Furthermore, some of them are very keen to share with me their stories, but due to limited time, only three months in the centre, I did not have the opportunity to listen to all of them.

I believe that their stories will help explore new areas in the mental health research. It is not only about the challenges, discrimination, and experiences of being a woman with mental health problem, but also the position of women with mental health problems in the society. For example, a woman told me she felt she was treated unfairly when her brother who also suffered from mental health problem is living at home with their family, whereas she was admitted to the centre. This might tell us more about the position of women in society. As a Chinese woman myself, it is more convenient for me to communicate and interact with them since Chinese residents make up the majority in the centre. Furthermore, due to the rapport building before and a private place provided, the women were willing to share their experiences.

#### **1.4 Research Questions**

The research questions for this study include:

- What are the experiences of women with mental health problems leading them to be admitted to the centre?
- What are the experiences of the women with mental health problems at the centre?

The main reason of developing these research questions is to understand the stories behind the women with mental health problems from their experiences that leading them to be admitted and stayed at the centre. It is also expected that different stories would open doors leading to sharing other experiences such as living experiences in the centre, discrimination experiences, and the women's position in society.

#### **1.5 Research Objectives**

The research objectives for this study are:

- To discover the experiences of women with mental health problems leading to admission to the centre
- To explore the experiences of the women with mental health problems in care centre

#### **1.6 Significance of Study**

This study seeks to understand the experiences of women with mental health problems who are currently staying at a care centre since there are limited studies conducted to explore the experiences of women diagnosed with mental health problems in a mental health care setting in Malaysia. This study will contribute to the knowledge base in relation to the experiences of women with mental health problems in a care setting in Malaysia. This is because there is not much academic work has been done to explore the experiences of people with mental health problems although there is emerging research focus on their

experiences in Malaysia which is similar to the western countries. Authors like Low and Lee (2015), explored the problems encountered by the people with mental health problems regarding the services provided by caregivers in a care setting in Malaysia. Low, Lee and Jacob (2017) had investigate the psychological distress faced and experienced by the residents in a care setting in Malaysia. Other than that, Crabtree (2004) had explored the experiences of female psychiatric patients in institutional care in Malaysia. The previous studies are focused on different aspects such as the challenges faced on the service provided, the psychological distress faced, and experiences in an institutional care. Hence, this study is significant as it's concerned about the experiences of the women that leading them to be admitted to the centre and their living experiences in the centre.

Although the findings of this study unable to explore the new areas in mental health research, new findings were found in this study such as the change of religion affiliation and the preferences of living at home as these findings are not found in the selected literature reviewed. Thus, the finding of this study will contribute towards the future research in relation to the cultural and mental health, as well as the help-seeking behaviour of the people with mental health problems. As this study was focused on the experiences of people with mental health problems, the outcomes of this study might improve the social work practices and mental health services. At the same time this study would also act as a platform for the women with mental health problems in the care centre to voice out their point of views on their experiences and feelings since women voices are often drowned out by the society. Therefore, the outcomes of this study would not only compromise the practice social workers and mental health professionals, but also influence the attitude and behaviour of the caregivers and society.

## **1.7 Structure of Thesis**

This thesis comprises of five chapters which begins with Chapter One, the introduction and ending with Chapter Five, the conclusion. Chapter One briefly discusses what the study is about. This chapter also explains the problem statement, research question, research objective, and significance of study.

The second chapter describes about the literature reviewed related to the international and local definitions of mental health and mental health problems, help-seeking behaviour, the existing mental health care services, and experiences of people with mental health problems. The feminist perspectives are also discussed in this chapter.

Chapter Three discusses about the research method used in this study. Mainly face-to-face in-depth interview, using an interview guide, were used to gather data. Participants were chosen using purposive sampling in the selected care centre. Thematic analysis used to analyse data are discussed in this chapter. The ethical consideration when conducting this study, insider perspective, and the limitations of this study are also discussed in this chapter.

Chapter Four presents the findings and discussion of this study. It focuses on answering the objectives of the research and presented the detailed descriptions of the participants' experiences that leading them to be admitted to the care centre and their experiences in the care centre. It starts with the discussion on the participants' experiences before admitted to the care centre. Then follow with the discussion on the participants' experiences in the care centre.

Finally, Chapter Eight summarizes the finding of this study. Follow by the recommendations for the future research and the implications of the findings on social work practices.



## CHAPTER 2

### LITERATURE REVIEW

In this section, I will first look at the international and local definitions of mental health and mental health problems, as well as the classification of common mental health problems to provide the understanding of mental health definition and situation in general and especially in Malaysia which consists of different ethnic groups and describes their help-seeking behaviour. The different mental health services components found across the world including Malaysia are also explored. Past studies on admission and subjective experiences conducted in western countries and in Malaysia are reviewed and discussed. Finally, the feminist perspectives in women health care are discussed.

#### 2.1 Definitions of Mental Health and Mental Disorders

Mental health is a term that is difficult to be definitive about as it is about more than just an absence of ill-health or illness, but an ideal definition is about the ability to achieve the potential as human beings (Penhale & Parker, 2008). A general description of mental health was used by the WHO which stressed the positive dimension of mental health and defined as

*“a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”*  
(WHO, 2014)

However, mental illness, mental distress, mental health problems and mental difficulties are different terms that used by professionals to refer to the same thing (Penhale & Parker, 2008). Mental disorder would be a more global term which generally covers any major withdrawal from “normal health” and comprises a few different illnesses and diseases

(Penhale & Parker, 2008). Throughout this study, the term “mental health problems” is being used because by adding the word “problems”, the “mental health” term can be connoted as a less stigmatize state and maybe less offensive to some parties (Pilgrim, 2009).

With the establishment of WHO in 1948 and after the publication of the International Classification of Diseases (ICD)<sup>6</sup>, a more international recognised classification of mental disorder was achieved (WHO, 2015). The two main medically accepted classification systems such as the ICD established by the WHO and the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM)<sup>7</sup> that used to classify the mental health problems or mental disorders have been adopted by the general health practitioners such as doctor and psychiatrists. As such, mental disorders or mental health problems defined by WHO as comprised

*“a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour, and relationships with others.”* (WHO, 2018)

Another definition of mental health problem has been provided by the DSM which is a classification system of mental disorders associated with designed criteria to facilitate the diagnoses of the disorders that developed by the American Psychiatric Association. There is no definite definition can capture all aspects of mental disorders in the range contained in the current version of DSM-5, but the definition of a mental disorder or mental health problem required to meet some elements as:

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<sup>6</sup> The abbreviation for International Classification of Disease - ICD will be used in the entire thesis. ICD is the standard diagnostic tool for epidemiology, health management and clinical purposes that used to monitor the incidence and prevalence of diseases and other health problem, providing a picture of the general health situation of countries and population (WHO, 2015).

<sup>7</sup> The abbreviation for Diagnostic and Statistical Manual of Mental Disorders – DSM will be used in the entire thesis.

*“a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.”* (American Psychiatric Association, 2013, p.20)

DSM is the standard classification of mental disorders with associated criteria designed to facilitate more liable diagnoses of the disorders used by mental health professionals in the United States (American Psychiatric Association, 2015) in the mental health field with successive editions over the past 60 years (American Psychiatric Association, 2013). It is designed to better fill the clinicians, patients, families, and researchers’ need for a clear and concise description of each mental disorder organized by explicit diagnostic criteria, supplemented by dimensional measures when appropriate that cross diagnostic boundaries, and a brief digest of information about the diagnosis, risk factors, associated features, research advances, and various expressions of the disorder (American Psychiatric Association, 2013). Hence, it is used by clinicians and researchers as a common language to communicate the characteristics of mental disorders that are presented by their patients (American Psychiatric Association, 2013).

Moreover, the use of the five axes that were popular in the previous edition, DSM-IV-TR, was discontinued in present edition, the DSM-V, but a focus on “dimensional approach” and easy path for modifications, as well as is structured to allow the diagnoses to be listed in order from initially in early childhood to adolescence and in adulthood (Ashley & Inks, 2014). Although there are different perspectives or models used to understand mental health, medical model (generally held by medical and some health practitioners that is basically concerned with disease and biomedical approaches) rather than social model (held

by practitioners such as social workers and is inclined to look at social factors of causation and also considers labelling as a contributory factor) (Penhale & Parker, 2008) was chosen in understanding mental health in this study. This is because the medical model is the dominant views about mental health without neglecting other views and it is useful for other practitioners such as social worker to have some knowledge and understanding about the medical model (Penhale & Parker, 2008). Therefore, the participants' mental health problems that diagnosed by the psychiatrist are understood by the researcher based on the medical model.

### **2.1.1 Classification of Common Mental Health Problems**

Depression, bipolar disorder, schizophrenia, and anxiety disorder are some of the mental health problems examples (Malaysian Mental Health Association, 2017). According to WHO (2018) and National Institute of Mental Health (2018), women predominate in the rates of common mental disorders such as depression, anxiety and somatic complaints, but are not significant in the severe mental disorders rates like schizophrenia and bipolar disorder. Only depression, bipolar disorder, and schizophrenia were discussed below because the participants in this study have been diagnosed with these mental health problems by the psychiatrist based on the globally accepted medical classification systems. It is also useful to know the existence of these manuals and the basis on which diagnoses are made (Penhale & Parker, 2008) to help the researcher to have a better understanding in mental health.

The classification of disorders in DSM is harmonized with the WHO's ICD, the official coding system that used in the United States, so that the DSM criteria define disorders are identified by ICD diagnostic names and code numbers (American Psychiatric Association, 2013). For example, in DSM-5, both ICD-9-CM and ICD-10-CM codes are attached to the relevant disorders in the classification. The classification system of disorder

is an important diagnosis aid for both the doctor and the individual as it represents groups or patterns of symptoms that might provide some hints and recommendations about what treatment might be needed and the management of the condition (Penhale & Parker, 2008).

Moreover, in order to improve the accurateness of diagnosis and the comprehensiveness of clinical assessment, the recent DSM version includes information on cultural concepts (American Psychiatric Association, 2013). The understanding of cultural context of illness experience is essential for effective diagnostic assessment and clinical management since it might reflect the influence of biomedical concepts (American Psychiatric Association, 2013). For example, the cultural terms and explanations should be included in case formulations when the disorder is diagnosed to help to clarify symptoms and etiological attributions, but the symptoms presented by the individuals with these cultural concepts should meet the DSM-5 criteria (American Psychiatric Association, 2013). Table 2.1 shows the summary of the classification of schizophrenia, depression, and bipolar disorder on the age onset and presenting symptoms.

**Table 2.1:** Classification of Mental Health Problems

<b>Mental Health Problems</b>	<b>Age Onset</b>	<b>Presenting Symptoms</b>
<b>Schizophrenia</b>	Appears during adolescence or early adulthood	Delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behaviour, negative symptoms
<b>Depression</b>	Might begin at any age, but more likely at puberty or late life	Presence of sad, empty, or irritable mood, somatic and cognitive changes
<b>Bipolar Disorder</b>	Bipolar I Disorder – begin around 18 years old and occurs throughout the life cycle Bipolar II Disorder- Occur at the mid-20s, can begin in late adolescence and throughout adulthood	Bipolar I Disorder – Manic episode and maybe followed by hypomanic or major depressive episodes Bipolar II Disorder – A current or past hypomanic or major depressive episode

(Source: American Psychiatric Association, 2013)

From the three mental health problems, schizophrenia is the most chronic and disabling mental health problems (National Alliance on Mental Illness, 2009a cited in Ambrosino et al., 2012) and according to WHO, it affected about 45 million people worldwide (Tan, 2005). Moreover, according to Cockerham (2000), it is also the most commonly diagnosed mental health problems and those who suffered from schizophrenia often require periodic hospitalization (Ambrosino et al., 2012; Cockerham, 2000). Based on the current DSM-5 (American Psychiatric Association, 2013), schizophrenia spectrum and other psychotic disorders include schizophrenia (lasts for 6 months and include at least 1 month of active-phase symptoms), other psychotic disorders, and schizotypal (personality) disorder. Most of the individuals with schizophrenia have suicidal thoughts and suicidal behaviour in response to hallucinations of self-harming or harming others (American Psychiatric Association, 2013).

The second mental health problem commonly diagnosed is depression which is more common among women than men. This is because depression affects nearly twice as many women as men and is the leading cause of disability which weakens many individuals for a period if left untreated (Ambrosino et al., 2012). In the current DSM-5 (American Psychiatric Association, 2013), depressive disorders have been separated from the bipolar and related disorder in DSM-IV, included disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified or unspecified depressive disorder. An individual who has experienced multiple and severe episodes, and persistence of mild depressive symptoms during remission has a higher risk of recurrence (American Psychiatric Association, 2013). Women have a higher risk of suicide attempts and occurrence of major depressive disorder that is 1.5 to 3 folds higher than males, but there are no differences between genders in symptoms (American Psychiatric Association, 2013).

Bipolar disorder is the third most commonly diagnosed mental health problem which is characterized as mood cycles interchanging between depression and mania, but more prominent in depression (Ambrosino et al., 2012). However, in the current DSM-5 (American Psychiatric Association, 2013), bipolar and related disorders are separated from the depressive disorders and placed between schizophrenia spectrum and other psychotic disorders and depressive disorders, such as bipolar I disorder, bipolar II disorder, cyclothymic disorder, substance/medication-induced bipolar related disorder, bipolar related disorder due to another medical condition, other specified or unspecified bipolar related disorder. According to DSM-5 (American Psychiatric Association, 2013), females with

bipolar I or II disorder are more likely to experience depressive symptoms, rapid cycling and mixed states, and have comorbidity patterns that differ from males such as eating disorders.

## **2.2 Mental Health Concepts in Malaysia**

According to Chong, Mohamad, and Er (2013), the definition of mental health by Malaysia Ministry of Health (MOH)<sup>8</sup> is different from WHO which shows more collective nature and this was traced back to the multi-cultural context of Malaysia (Deva, 2004) because what mental health really is depended on the different perspectives of every culture and every individual (Haque, 2005). In Malaysia, the National Mental Health Policy defined mental health as

*“The capacity of the individual, the group, and the environment to interact with one another to promote subjective well-being and optimal functioning, and the use of cognitive, affective and relational abilities, towards the achievement of individual and collective goals consistent with justice.”*  
(cited in Haque, 2005, p.183)

Moreover, the meaning of mental disorder that is defined in the Mental Health Act 2001<sup>9</sup> as

*“Any mental illness, arrested or incomplete development of the mind, psychiatric disorder or any other disorder or disability of the mind.”*  
(Mental Health Act 2001, 2006)

In addition, the different perspectives on the mental illness and mental health concepts in Malaysia influenced by various ethnic and religious beliefs (Chong, Mohamad, & Er, 2013) since Malaysia consists of different ethnic groups, from the three main ethnic

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<sup>8</sup> The abbreviation for Ministry of Health – MOH will be used in the entire thesis.

<sup>9</sup> Mental Health Act 2001 is also known as Act 615 is an act that consolidate the laws relating to mental disorder and provide for the admission, detention, lodging, care, treatment, rehabilitation, control and protection of persons who are mentally disordered and for related matters (Mental Health Act 2001, 2006).



groups - Malays, Chinese, and Indians in Peninsular Malaysia to the indigenous tribes – Iban, Melanau, and Kadazan-Dusun in East Malaysia, with diverse cultures and religious backgrounds. Although the official religion of Malaysia is Islam which is affiliated by the Malays, other ethnic groups have the liberty to practice other religions, such as the Chinese affiliating with Christianity or Buddhism, while the Indians adhere to Hinduism. Since the study was conducted in Peninsular Malaysia, thus only the perceptions and views on mental health and mental disorder of the three main ethnic groups were relevant and discussed below. The researcher also used these cultural perspectives in understanding the participants' perception on mental health problems and help-seeking behaviour.

### **Malay Culture**

Spiritual and religious factors played an important role in the mental health concept in the Malay culture. It is common to label mental illness as “*sakit jiwa*” which refer to the illness of the soul (Chong, Mohamad, & Er, 2013) among the Malays. Another belief related to “*angin*” refers to the wind present in the stomach, nerves, and blood vessels that lead to hallucinations and delusion (Haque, 2005). The possession of *Jinn* is also the common belief in the Malay culture, the Malays believe that the *Jinn* might possess the victim's ancestor which wish to stay in their offspring's bodies after death. When the possessed person refused the *Jinn* to stay in their body, problems will arise (Haque, 2005). “*Santau*” or black magic is another factor that led to psychological problems which practiced to carry out revenge, envy, or gain personal strength by using traditional ingredients mixed in food or drinks or through *Satan* or *Jinn* (Haque, 2005).

Due to the strong connotations of mental illness with supernatural causes in the Malay cultural belief systems such as charms and evil deeds, and a person's spirit weakness, majority Malays believed that mental illness is not only a medical illness, but also perceived

as spirit possession or a social punishment (Deva, 2004). Cultural belief systems then led the people to seek traditional help from traditional healer such as “*bomoh*” or “*pawang*” who are considered as possessors of hidden knowledge and can free the individual from possession and cure psychological illness (Haque, 2005). Consequently, the strong religious influence resulted in the general mental illness concept in the Malay society as a result of abandoning or neglecting traditional values (Haque & Masuan, 2002).

### **Chinese Culture**

The Chinese belief system is a mixture of Tao, Buddhist, and Christian philosophies as well as ancestral worship (Haque, 2008). The views on mental health problems were primarily shaped by traditional Chinese philosophies of the mind and mental activities as a result of somatic activities and depended on the physical health that is proposed by the Chinese holistic theory of body and mind (Haque, 2010). In the Chinese culture, both mental and physical illness is believed to be caused by the lack of spirit or weakness of *yin* and *yang* (Chong, Mohamad, & Er, 2013). Good physical and mental health is attributed to one’s emotions state (Haque, 2010) which is an integral aspect of the body’s basic functions and is regulated by the circulation of *ch’i* (air) that is partly intrinsic and partly a product of the individual’s food and drink (Haque, 2008). *Ch’i* not only maintains one’s physical body, but also the mental and spiritual processes (Chong, Mohamad, & Er, 2013; Haque, 2008, 2010). Thus, excessive, unbalanced, and undisciplined emotions trigger any kind of illness (Haque, 2008, 2010; Toran, Squires, & Lawrence, 2011).

The Chinese also believed that mental illness is caused by problems related to self-worthiness measured by the material achievement such as education, occupation and monetary gain that are expected to bring honour to the family (Chong, Mohamad, & Er, 2013) since the Chinese values is very important for the Chinese society (Haque, 2005). Moreover,

Chinese people also believe in pantheon of powerful spirits that can be influenced by humans through certain rituals (Haque, 2008, 2010). These spiritual beings are known as “*Shen*” in Chinese which can possess the mediums through their trances and deal with devils and deities to bring a change in the suffering person (Haque, 2008, 2010). Thus, it is also common for the Chinese to seek treatment from traditional Chinese healers or other healers (Supernor, 1983; Kinzie et al., 1976 cited in Edman & Teh, 2000).

Some of the Chinese Malaysians are affiliated with Christianity. According to the Christian worldview, mental disorders are attributed caused by the nature where the life challenges and the wrongdoings by humans are ultimately controlled by God and this also means no illness can inflicted upon a person without the will of God (Haque, 2005). Illness might be imposed upon an individual in order to bring about changes in his/her life, to teach patience, and to increase trust in God (Haque, 2005). Moreover, the factors of psyche or spiritual are important for mental health and used in the treatment for mentally ill persons (Haque, 2005). True mental health is possible with the right relationship with God according to Christianity (Haque, 2005).

A few Chinese Malaysians also practiced Buddhism. According to the Buddhist philosophy, life is full of sufferings (*dukkha*) for those who crave for this world (*samdaya*) but can be ended (*nirodha*) by terminating of desire that leads to ultimate happiness state (*nirvana*) (Haque, 2005). Buddhists believe in Karma and thus attributed mental health as the results of negative behaviours done in the past and good mental health required to fulfil the qualities of right understanding, right thought, right speech, right action, right livelihood, right effort, and right mindfulness (Haque, 2005). Medications, diet, and disciplined behaviours are necessary for promoting personal development (Haque & Masuan, 2002).

## Indian Culture

Majority of the Indians in Malaysia practice Hinduism. In the Hindu textbook, *Vedas* (Book of Knowledge) is found to have strong influence of Hinduism of the illnesses and treatment (Chong, Mohamad, & Er, 2013). For those who are affiliated with Hinduism often follow the *Ayurvedic* philosophy which teaches that physical and mental health is a result of balance between mind, body, and soul since Indians believed that illnesses are caused by supernatural forces and can be treated by using *Ayurveda* (Pflug, 1992 cited in Chong, Mohamad, & Er, 2013). Mental health is also attributed by Hinduism relating to diet, relationship between one's with the gods, teachers, and the Brahmins (Haque, 2005). Thus, these Indians would also seek treatment of *Ayurveda* and temple healers for people with mental illness (Deva, 2004).

In conclusion, different cultures are practiced in Malaysia because it consisted of multiple ethnic groups such as Malay, Chinese, Indian, and Bumiputera from Sabah and Sarawak. However, a few Chinese, Indian, and Bumiputera from Sabah and Sarawak would affiliate with different religions as stated in the Malaysia Federal Constitution (2010) which have influenced their perceptions on both physical and mental health. Therefore, Malaysians view mental health concepts differently based on their different cultural belief systems. Although the Malaysians hold different perspectives on mental health concepts, they shared a similarity that is seeking help from the traditional healers such as Malay "*Bomoh*", Chinese mediums, and Indian temple healers to cure their mental health problems. Thus, different cultural and belief systems that are upheld by Malaysians from various parts of the country not only impact their perceptions and views on mental health concepts, but also affect their help-seeking behaviour.

### 2.3 Help-Seeking Behaviour

People diagnosed with mental health problems in Malaysia tend to seek informal help from families, friends, and traditional healer first before any formal psychiatric care (Lim, 2015; Mohamad et al., 2012) because according to their perception the disorder does not require professional care (Abdul Kadir & Bifulco, 2010) and the strong influence of culture, religious, and traditional backgrounds on mental illness and mental health (Chong, Mohamad, & Er, 2013) as discussed in Chapter Two section 2.2 (pp. 18-22) greatly influence their help-seeking behaviours. Thus, it is important to know about the help-seeking behaviour of people with mental health problems in Malaysia to help them to receive the proper health care before the disorders becomes severe.

David Mechanic provided one of the earliest definitions of help seeking as “*an adaptive form of coping*” (Rickwood, Thomas, & Bradford, 2012) and later it was defined as “*the behaviour of actively seeking help from other people*” by Rickwood et al. (2005). Help seeking was considered as communicating with others to obtain assistance in terms of understanding, advice, information, treatment, and general support in response to a problem or distressing experience and was understood as an active and problem-focused coping form which relied on other people’s external assistance (Rickwood, Thomas, & Bradford, 2012).

Help can be sought from various external sources such as people who occupy different roles and differ in terms of their relationship with the person seeking help (Rickwood, Thomas, & Bradford, 2012). The two main clarified types of help-seeking are formal and informal (Tung, 2011). Formal help-seeking behaviour “*includes individuals’ tendency to seek support from the existing college help or support services*” (Onditi, Moses, & Masath, 2014) such as trained general practitioners including counsellors, psychologists, and general practitioners (Price & Dalglish, 2013). Informal help-seeking refers to “*the*

*assistance from informal social networks, such as friends and family”* (Rickwood, Thomas, & Bradford, 2012).

Moreover, culture affects *“the way people label illness, identify symptoms, seek help, decide whether someone is normal or abnormal, set expectations for therapists and clients, give themselves personal meaning, and understanding morality and altered states of consciousness”* (Ridley, Li & Hill, 1998). Kleinman, Eisenberg and Good (1978) stated that a purely biomedical model for mental illness that is used by mental health professionals is inadequate for appropriate assessment and treatment in a multicultural society since cultural beliefs affect how a person perceives health problems, the presenting ways of symptoms, when and to whom to go for care, how long to remain in care, and how to evaluate that care (Seah et al., 2002).

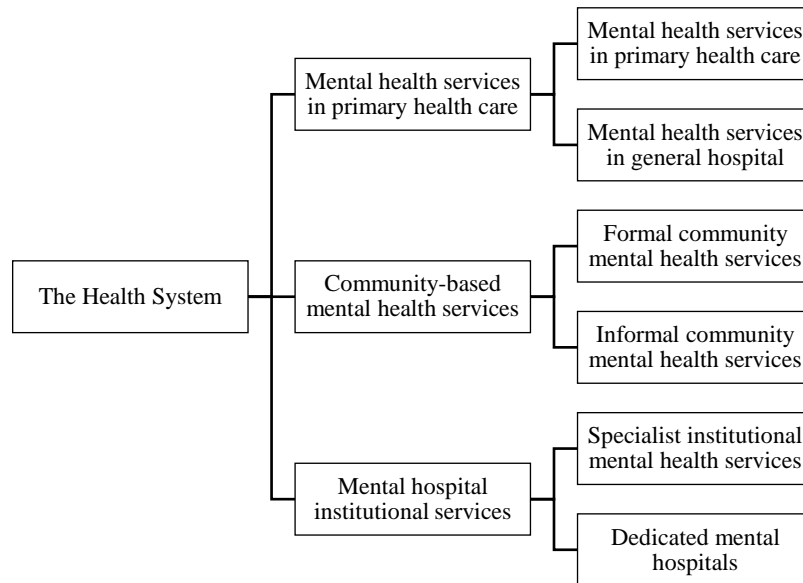
For example, Malaysia consisted of three main ethnic groups - Malay, Chinese and Indian whose cultural beliefs have strong influence in the perceptions of health and treatment (Zain, 2001). Malays who are Muslims believed that illness is a God’s punishment for wrongdoing (Centre of Excellence in Culturally, n.d.) thus leading them to seek help from traditional healers’ such as *“bomoh”* or *“pawang”* (Chong, Mohamad, & Er, 2013). Chinese who are Buddhists believed that the worship of Buddha can help to recover since the illness is due to the impurity of their soul, whereas Chinese who are Christians believed that church is a good place to get therapy through socialising (Mohamad et al., 2012). Indians who are Hindus believed that spiritual treatment in the Hindu temple can enhance the person’s health (Mohamad et al., 2012). Therefore, Malaysians tend to seek formal psychiatric care after informal help such as traditional treatment for their mental health problems (Abdul Kadir & Bifulco, 2010) because the perceptions of health and mental health were influenced by their

cultural and religious systems. Despite seeking informal health, some Malaysians would seek formal health care that available in Malaysia.

### **2.3.1 Mental Health Care Services in Other Countries**

The formal health system across the world consists of mental health services in primary health care, community-based, and hospital-based (WHO, 2003). Mental health care service has shifted from mental hospitals to community-based settings during the mid-20<sup>th</sup> century not only in Western countries but also in Malaysia (Salisbury, Killaspy, & King, 2016). This is a deinstitutionalization process (Dahlan et al., 2013) advocated by WHO (Salisbury, Killaspy, & King, 2016) was driven by public awareness and violation of human rights faced by people diagnosed with mental health problems, high cost of mental hospitals, and the effective psychotropic medication (Novella, 2008).

WHO had developed a module of mental health policy and service guidance package to provide practical information to assist countries and to improve their populations' mental health (WHO, 2003). The package modules are designed to assist countries in policy development and service planning and the exact form of service organization and delivery depending on the country's social, cultural, political, and economic context since this package does not attempt to propose a single model for the service organization in a global context (WHO, 2003). Figure 2.1 shows the schematic representation of different mental health services components found across the world.



**Figure 2.1:** Components of the mental health services in other countries  
(Source: WHO, 2003)

As shown in Figure 2.1, other countries' mental health services in primary health care can be grouped in primary health care and the general hospital. Those primary care services includes treatment, preventive and promotional activities delivered by primary care professionals such as general practitioners, nurses, and other health staff based in primary care clinics, while those services offered in district general hospitals include psychiatric inpatient wards, psychiatric beds in general wards and emergency departments, and outpatient clinics and some specialist services that are provided by specialized mental health professional such as psychiatrists, psychiatric nurses, psychiatric social workers, psychologists, and physicians who received psychiatry special training (WHO, 2003).

Community mental health services in other countries can be grouped as formal and informal (WHO, 2003). Formal community-based mental health services includes community-based rehabilitation services, hospital diversion programmes, mobile crisis teams, therapeutic and residential supervised services, home help and support services, and community-based services for special groups of people which requires some high level skills



and training staff and would also need to work closely with general hospitals and mental hospitals, whereas informal community-based mental health services include the services provided by local community members such as traditional healers, religious leaders, village or community workers, family members, and self-help groups (WHO, 2003). Institutional mental health services in other countries can be grouped as specialist institutional services and mental hospitals as shown in the figure above. Specialist institutional mental health services offer various services in inpatient wards and in specialist outpatient clinic settings which are provided by certain outpatient clinics and public or private hospital-based facilities, while dedicated mental hospitals provided long-stay custodial services (WHO, 2003).

Since WHO cooperates with the Malaysian government in support of the national health policies, strategies and plans on health (WHO, 2017) and the mental health policy and service guidance package module that are developed by WHO do not try to propose a single model for the service organization in a global context (WHO, 2003), Malaysia has established a mental health service framework in 2001 as a blueprint for planning, implementation, and evaluation of mental health services in lined with the developed National Mental Health Policy in 1998 (Ministry of Health Malaysia, 2011). The Malaysia MOH introduced the Mental Health Act 2001 that contains detailed policy guidelines for services delivery, enforced in 2010 together with the Mental Health Regulations 2010 (Khan et al., 2015). The MOH also issued the Psychiatric and Mental Health Services Operational Policy in 2011 to further strengthen the psychiatric and mental health services and support the implementation of the Mental Health Act 2001 and Mental Health Regulations 2010 (Ministry of Health Malaysia, 2011). Table 2.2 shows the scope of services in the Malaysia Psychiatric and Mental Health Operational Policy.

**Table 2.2:** Scope of Services in the Malaysia Psychiatric and Mental Health Services Operational Policy

<b>Health Care Facilities</b>	<b>Services Provided</b>
<b>Primary Care</b>	<ul style="list-style-type: none"> <li>• Promotion of mental health</li> <li>• Early detection and prompt treatment</li> <li>• Follow-up of stable cases and defaulter tracing</li> <li>• Psychosocial rehabilitation (PSR)</li> </ul>
<b>Hospital with No Resident Psychiatrist</b>	<ul style="list-style-type: none"> <li>• Promotion of mental health</li> <li>• Early detection and prompt treatment</li> <li>• Follow-up of psychiatric patients and defaulter tracing</li> <li>• Inpatient care (Optional)</li> </ul>
<b>Hospital with Resident Psychiatrist</b>	<ul style="list-style-type: none"> <li>• Promotion of mental health</li> <li>• Early detection and prompt treatment</li> <li>• Specialist outpatient care</li> <li>• Inpatient care</li> <li>• Hospital-based community psychiatry</li> <li>• Psychosocial interventions</li> <li>• Liaison consultation services</li> <li>• Subspecialised services e.g. child and adolescent psychiatry, geriatric psychiatry, etc. (Optional)</li> <li>• Research</li> <li>• Training</li> </ul>
<b>Mental Institution</b>	<ul style="list-style-type: none"> <li>• Promotion of mental health</li> <li>• Early detection and prompt treatment</li> <li>• Specialist outpatient care</li> <li>• Inpatient care</li> <li>• Hospital-based community psychiatry</li> <li>• Psychosocial interventions</li> <li>• Forensic psychiatry</li> <li>• Residential care for hard to place patients and long stay patients</li> <li>• Research</li> <li>• Training</li> </ul>

(Source: Ministry of Health Malaysia, 2011)

### **2.3.2 Mental Health Services from Colonization to Independence in Malaysia**

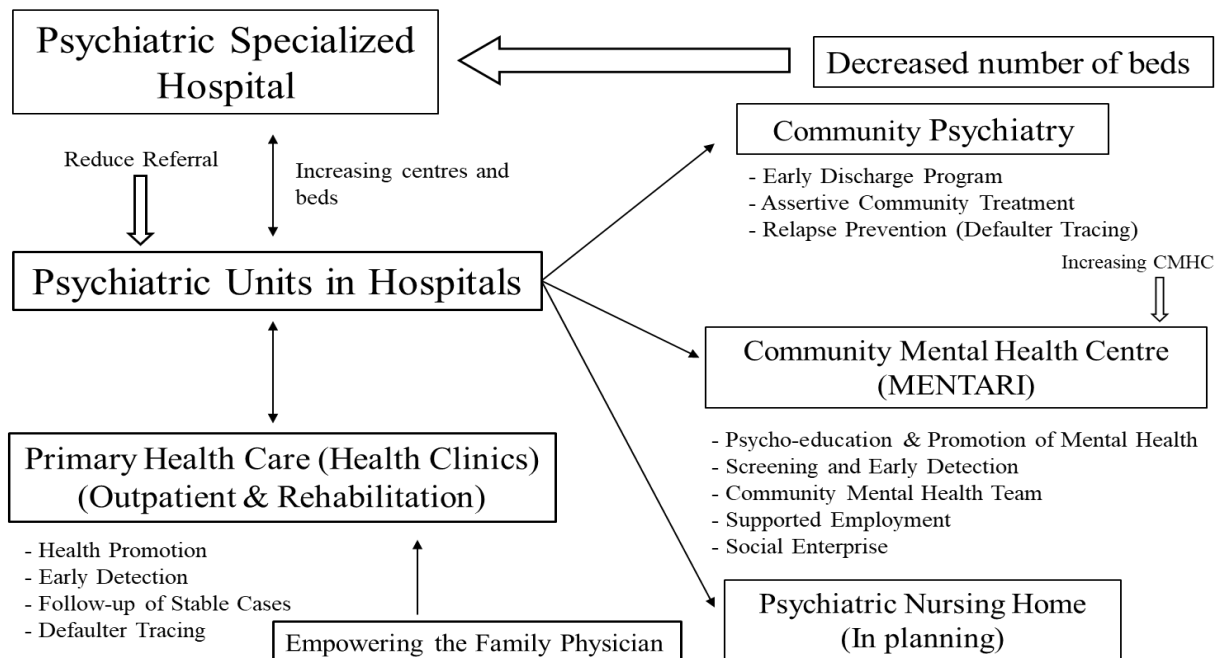
The start of mental health services in Malaysia can be traced back to the end of the 1890s when the first set up of small scale “lunatic asylum” at the Penang Hospital which is situated at the north of Peninsular Malaysia (Chong, Mohamad, & Er, 2013). Later, four facilities were designed as a hospital, but treatment remained in the custodial nature were established such as the Federal Lunatic Asylum or Hospital Bahagia near Tanjong Rambutan, Perak in 1911, Permai Hospital in Johor in 1935, and Bukit Padang Hospital in Sabah and Sentosa Hospital in Sarawak in 1920s, although there was record of psychiatric hospital in Taiping Hospital in 1910 (Chong, Mohamad, & Er, 2013). The mental health care provision revolution started in 1958 when the mental health ward was first opened at the Penang General Hospital (Haque, 2001) where the mental health service users are treated in a non-psychiatric hospital (Chong, Mohamad, & Er, 2013). The first community-based rehabilitation day care centre was opened at Ipoh, Perak in 1967, and the first professional psychiatrist started practising in Malaysia in 1961 (Chong, Mohamad, & Er, 2013).

Mental health services have undergone changes all over the world including Malaysia, from asylums, traditional custodial care in mental institutions towards an effective and comprehensive community care (Abdul Kadir Abu Bakar, 2011). The community mental health services in Malaysia have been gradually incorporated into the existing services since 1990s (Ruzanna & Marhani, 2008) in order to increase the accessibility of the service by the general population and to support the downsizing of mental hospitals (Dahlan et al., 2013). A few community-based psychiatric clinics were built unevenly over the country as a result of deinstitutionalization (Crabtree & Chong, 2001).

According to Chong, Mohamad, and Er (2013), Malaysia has also moved towards treating mental health services users in community-based care since it has become an

accepted form in the Mental Health Act 2001 which comprises detailed policy guidelines for the delivery of mental health services. The Act has been amended to include a new strategy to promote community mental health services resulted in discharging patients to the community with the available support from the community clinics and general hospitals because caring and supporting people with mental health problems in the least restrictive environment is now the focus of the Malaysian National Health Strategy (Chong, Mohamad, & Er, 2013).

Mental health care system in Malaysia has integrated into primary health care clinics which is managerial under the MOH's public health division and separated from general health system to reduce stigma and encourage the public to seek treatment early (Ministry of Health Malaysia, 2017). Figure 2.2 shows the government mental health services in Malaysia.



**Figure 2.2:** Government mental health services in Malaysia  
(Source: Ministry of Health Malaysia, 2017)

Based on the Mental Healthcare Performance Report 2016, the primary care service focuses on mental health promotion, early detection and treatment, following up of the stable cases, psychosocial rehabilitation, and family intervention (Ministry of Health Malaysia, 2017). Simultaneously, resident psychiatrists are post to all state hospitals and major specialist hospitals to provide comprehensive psychiatric services which include outpatient care, inpatient care, psycho-education programme, rehabilitation services, community mental health care centre, psychiatric nursing home, and family intervention (Ministry of Health Malaysia, 2017). Efforts are made to strengthen and increased the mental health care services in the community to work towards reduction of referrals and downsize mental institution (Ministry of Health Malaysia, 2017).

Since the Malaysian government promoted community mental health care by discharging the long-stay mental health service users into the community, many family caregivers are responsible for taking care of their relatives with mental health problems in their community (Chong, Mohamad, & Er, 2013). However, the families of relatives with mental health problems prefer their relatives to be in institutionalized although the Malaysian families traditionally choose to take care of their relatives with illness at home and hospitals are considered as a last resort (Deva, 2004). This is mainly caused by the myth or misunderstanding or lack of knowledge and literacy about mental health and mental health problems, as well as the devotion to the traditional cultural beliefs systems that are practiced by the multi-ethnic groups in Malaysia (Malaysian Psychiatry Association, 2005 in Chong, Mohamad, & Er, 2013). Therefore, people with mental health problems are more likely admitted to institution or residential care centre rather than getting cared for by family members at home.

Admission to a psychiatric nursing home would be the choice for the family members to admit their relatives with mental health problems since a psychiatric nursing home is an intermediate care facility and a home that provide accommodation, nursing, and rehabilitation for people with mental health problems (Malaysia Mental Health Act 2001, 2006; Ministry of Health Malaysia, 2011). The admission information of people with mental health problems into government, private and gazetted private psychiatric nursing home have mentioned in the Malaysia Mental Health Act 2001 (2006) under section 31.

Under section 31 subsection 1 of the Malaysia Mental Health Act 2001 (2006), admission to a government, private, and gazetted private nursing home would be as a voluntary patient or upon request of a relative or the medical director of a psychiatric hospital. No person would be admitted into a psychiatric nursing home without the request of a medical officer or registered medical practitioner who is preferable a psychiatrist under section 31 subsection 2 of Mental Health Act 2001 (2006). The purpose of admitted a patient to the psychiatric nursing home (referred to in subsection 1) is to provide him or her with accommodation, nursing, and rehabilitative care under section 31 subsection 3 (Mental Health Act 2001, 2006). A patient who is admitted under section 31 or his relative may request for discharge from the psychiatric nursing home by giving notice to the person in charge, and the patient shall not be kept in the psychiatric nursing home for more than twenty-four hours upon such request once notice was received by the person in charge under section 31 subsection 4 (Mental Health Act 2001, 2006).

The patient who were admitted to the nursing home will be reviewed by a medical officer within the week which include a review of physical and mental state, the nursing and individual care plan, as well as medication and later, the patients will be examined by a medical officer at least once in two weeks (Ministry of Health Malaysia, 2011). Family and

friends are encouraged to visit the patients who are admitted to the nursing home and involved in all aspects of the rehabilitative process by providing family education, teaching communication, problem solving, and stress management skills (Ministry of Health Malaysia, 2011).

## **2.4 Experiences of People with Mental Health Problems**

People with mental health problems have been affected by stigma and discrimination (Buizza, et al., 2007; Lauber & Rossler, 2007; Lee et al., 2005; Peterson et al., 2006). In a review paper that was published by Lauber and Rossler (2007), the summarized result shows that people with mental health problems in Asia (Malaysia) have the tendency to be stigmatized and discriminated as compared to those in western countries. Stigma can be understood in stereotypes which refers to a negative belief about a group (e.g., dangerousness, incompetence, character weakness), prejudice refers to agreement with belief and/or negative emotional reactions (e.g., anger, fear), and discrimination refers to behaviour response to prejudice (e.g., avoidance, withhold employment, housing opportunities, and help) (Corrigan & Watson, 2002).

Stigma is a socially constructed phenomenon where a person is perceived differently from others leading to discrimination, while discrimination is defined as “being treated unfairly or denied opportunities” (Harrison & Gill, 2010). Stereotypes held by the public, the role of supernatural and religious perspectives, mental health care accessibilities, and attitude of mental health professionals further stigmatize people with mental health problems (Lauber & Rossler, 2007). Stigmatization has impacted the experiences of people with mental health problems and lead to social isolation, limited life chances and delayed help-seeking behaviour (Harrison & Gill, 2010).

In order to explore the experiences of the participants, some past studies have been selected and reviewed especially on stigmatization and discrimination since the experiences of people with mental health problems were influenced by stigma. The selected literature reviewed showed that people with mental health problems such as schizophrenia, depression, and bipolar disorder face more stigmatization and discrimination as compared to individuals with other health problems not only in western countries, but also in Malaysia (Buizza et al., 2007; Hanafiah & Bortel, 2015; Lee et al., 2005; Peterson et al., 2006; Razali & Ismail, 2014; Tuti et al., 2009).

Due to the stigma, people with mental health problems have been discriminated from employment, education, housing, mental and other health services, and social exclusion (Buizza et al., 2007; Hanafiah & Bortel, 2015; Peterson et al., 2006; Razali & Ismail, 2014). Moreover, the selected literature reviews conducted in other countries shows that family, friends, and colleagues are the main perpetrators of discrimination (Buizza et al., 2007; Lee et al., 2005; Peterson et al., 2006; Tuti et al., 2009), while a past study conducted by Razali and Ismail (2014) in Malaysia shows the general public stigmatize people with mental health problems more often than the relatives of the individual diagnosed with mental health problems because the relatives tend to have a better perceptions as a result of their life experiences. Table 2.3 shows the summary of the selected literature reviews conducted on stigmatization and discrimination experiences in other countries.



**Table 2.3:** Summary of Selected Reviewed Studies on Stigmatization and Discrimination Experiences in Other Countries and in Malaysia

<b>Literature Review on Stigmatization and Discrimination Experiences in Other Countries</b>		
<b>Study References</b>	<b>Objectives</b>	<b>Findings</b>
<b>Buizza, Schulze, Bertocchi, Rossi, Ghilardi, and Pioli (2007)</b>	To identify and to understand the stigma from the perspective of people with schizophrenia and their relatives in an Italian rehabilitation residential care unit	Experiences of stigmatization: Stigma in the context of psychiatric treatment, community attitudes/prejudices, self-stigma, exclusion from the social life, lack of comprehension, negative public images, exclusion from job/study, and lack of or wrong information 4 dimensions of stigma: Access to social roles, quality of mental health services, internalized stigma about mental illness, and public image of mental illness
<b>Lee, Lee, Chiu, and Kleinman (2005)</b>	To document and compare the interpersonal experiences of stigma in patients with schizophrenia and patients with diabetes mellitus in Hong Kong	Significantly more patients with Schizophrenia than diabetes experienced stigma from family members, partners, friends, and colleagues. Over 50% anticipated stigma and about 55% concealed their illness.
<b>Peterson, Sheehan, Pere, and Surgenor (2006)</b>	To describe the nature of discrimination that people with experience of mental illness face in New Zealand	Areas of reported discrimination: Employment, education and training, housing, mental health services and other health services, government agencies and local government services, financial institutions, sports clubs and other organized activities, parenting, friends and family, community harassment, fear of discrimination

**Table 2.3** continued

<b>Literature Review on Stigmatization and Discrimination Experiences in Malaysia</b>		
<b>Study References</b>	<b>Objectives</b>	<b>Findings</b>
<b>Hanafiah and Bortel (2015)</b>	To investigate perspectives on stigma and discrimination of mental illness from the point of view of mental health professionals in Malaysia	7 principle themes: Perpetrators, types of mental illness carrying stigma, demography and geography of stigma, manifestations of stigma, impact of stigma, causes of stigma, and proposed initiatives
<b>Razali and Ismail (2014)</b>	To compare the stigmatizing attitude towards patients with schizophrenia between the general public, relatives of patient with schizophrenia and relatives of patient with neurotic illnesses	The scores of both social distance (SD) and stereotypical beliefs (SB) were consistent with each other, which reflected that far social distance and more negative attitudes were strongly adopted by the general public. There were significant differences in the total and most of the individual item scores of the SDS and SB between the general public and the two relative groups. However, the difference in the SDS scores between the relatives of patients with schizophrenia and neurotic illnesses was not significant. Among the socio-demographic factors, educational status had a stronger influenced on stigma than age and sex.
<b>Tuti, Nursyuhaida, Nik Siti Fatimah, Faridah Hanim, Nor Akmar, Effa, Khairunnisa, Marhani, and Ruzanna (2009)</b>	To compare the stigma experience between mentally ill patients and diabetic controls, focusing on stigma arising from family members in Hospital Taiping, Malaysia	Significantly higher percentage of psychiatric patients (55.6%) experienced stigma compared to diabetic patients (15.4%). Moreover, significantly higher comments percentage of psychiatric patients received comments during the relapse of illness.

People with mental health problems struggle with the symptoms and disabilities, as well as the stereotypes and prejudice that result from the misconceptions about mental illness (Corrigan & Watson, 2002) such as people who were ever diagnosed with a mental disorder can never be normal, and mentally ill people are dangerous (Malaysia Psychiatric

Association, 2006). Due to the misconceptions about mental illness, the patients often experience discrimination such as social avoidance where the public try to avoid interaction with them, isolation in institution (Corrigan & Watson, 2002), and coercive treatment by disconnecting from decision-making processes (Murphy et al., 2017).

Previous studies were conducted to explore the experiences of the people with mental health problems on their care pathways which showed that they were forcefully enrolled to mental health services (Lawlor et al., 2010; Murphy et al., 2017; Pescosolido, Gardner, & Lubell, 1998) due to stereotyping and discrimination (Lawlor et al., 2010). In order to explore the experiences of the participants in decision making in receiving healthcare, some past studies have been selected and reviewed since the service users in the previous study were forcefully enrolled to mental health services. The selected literature reviewed in the western countries showed that the mental health care service users preferred and desire to participate actively in decision making for service use (Dahlqvist\_Jonsson et al., 2015; Cosh et al., 2017), while the past study conducted by Ambigapathy, Chia, and Ng (2016) in Malaysia showed that the patients preferred shared decision making in clinical consultation which the doctor's perception contradict with the patients preferred roles (e.g., active and shared role) in clinical decision making.

Moreover, studies done by Dahlqvist\_Jonsson et al. (2015) and Cosh et al. (2017) in western countries were conducted with people with mental health problems in mental health services, but Ambigapathy, Chia, and Ng (2016) conducted the study with patients attending primary care clinic in Malaysia which was one of the few studies performed in looking specifically at the patient's preferred role in decision-making. Although past studies used different data collection methods and were conducted at different health care services with different individuals, these studies focused on exploring the participants' experiences on

decision making in receiving health care. Table 2.4 shows the summary of the selected literature reviews that were conducted on decision making experiences in other countries and in Malaysia.

**Table 2.4:** Summary of Selected Reviewed Studies on Experiences in Decision Making in Other Countries and in Malaysia

<b>Literature Review on Experiences in Decision Making in Other Countries</b>		
<b>Study References</b>	<b>Objectives</b>	<b>Findings</b>
<b>Cosh et al. (2017)</b>	To explore relationships between preferences for and experiences of clinical decision making (CDM) with service use among persons with severe mental illness across Europe	A preference by patients and staff for active patient involvement in decision making, rather than shared or passive decision making, was associated with longer hospital admissions and higher costs at baseline and with increases in admissions over 12 months. Low patient-rated satisfaction with an experienced clinical decision was also related to increased costs over the study period.
<b>Dahlqvist_Jonsson, Schon, Rosenberg, Sandlund, and Svedberg (2015)</b>	To explore user's experiences of participation in decision in mental health services in Sweden, and the kinds of support that may promote participation	Core Category: Struggle to be perceived as a competent and equal person 3 related categories: being underdog, being controlled, and being omitted The finding also emphasize internal conditions (e.g., feeling respected as a person, feeling confidence in one's ability) and external conditions (e.g., having personal support, access to knowledge, a dialogue, and clarity about responsibilities) to promote the respondent's participation in decision making

**Table 2.4** continued

<b>Literature Review on Experiences in Decision Making in Malaysia</b>		
<b>Study References</b>	<b>Objectives</b>	<b>Findings</b>
<b>Ambigapathy, Chia, and Ng (2016)</b>	To determine Malaysian patients' role preference in decision-making and the associated factors	Shared decision-making was preferred by 51.9% of patients, followed by passive (26.3%) and active (21.8%) roles in decision-making. Higher household income was significantly associated with autonomous role preference. Doctors' perception did not concur with patients' preferred role, among patients whom doctors perceived to prefer a passive role, 73.5% preferred an autonomous role.

Discrimination as a result of stigmatisation (Harrison & Gill, 2010) has restricted the rights and freedom of people with mental health problems (Lauber & Rossler, 2007). For example, people with mental health problems are stereotyped as dangerous, violent, and unpredictable and thus should be locked away in an institution (Lauber & Rossler, 2007; Malaysian Psychiatric Association, 2006). In order to reduce stigmas, one of the strategies is to provide opportunities for the public to meet with patients diagnosed with mental health problems who live in the community (Corrigan & Watson, 2002). The development of community-based services has met this need (Gilburt et al., 2010). In Malaysia, with the introduction of National Mental Health Act in 2001, the people with mental health problems were being discharged from institutions and placed in community care centres (Low, Lee, & Jacob, 2017).

Hence, researches have been carried out to explore the experiences of the people with mental health problems in community-based mental health services. The selected past studies in other countries on exploring the experiences in mental health care services, reported that these community-based services have greater levels of satisfaction as compared

to traditional in-patient services (Gilburt et al., 2010; Johnson et al., 2004; Osborn et al., 2010). The service users in community-based services in other countries were found to have more freedom, have more “voice”, and have less paternalistic staff (Gilburt et al., 2010; Johnson et al., 2004; Osborn et al., 2010). However, the study conducted in Malaysia by Low and Lee (2015) showed that service users have different experiences with the service users in other countries who need better health care services such as trained caregivers and caregivers with more empathy. Another study carried out in Malaysia by Low, Lee and Jacob (2017) showed that the service users in community-based services need family support, to preserve their integrity, to get empathy from the caregivers, experienced stigmatisation, and desire for social acceptance.

These selected literature reviews were found to be applicable for this study because of the qualitative studies conducted through interview focusing on the participants’ views on their experiences in a community-based mental health care setting (Gilburt et al., 2010; Johnson et al., 2004; Low & Lee, 2015; Low, Lee, & Jacob, 2017; Osborn et al., 2010). However, the past study conducted by Johnson et al. (2004) focused on the women’s experiences between a women crisis house with the acute hospital wards, while the studies carried out by Gilburt et al. (2010) and Osborn et al. (2010) focused on the female and male respondents’ experiences between residential alternatives to standard acute wards. The two studies by Low and Lee (2015), and Low, Lee and Jacob (2017) focused on the experience as a service user in utilising mental health care services rather than their living experiences.

Moreover, the study conducted by Osborn et al. (2010) compared and explored the male experiences between the residential alternatives and the acute in-patient care in England by using validated measures. Although there are differences found between these selected past literatures, the results found contributed to this study specifically in comparing the

experiences of patients diagnosed with mental issues in mental health care settings. Table 2.5 shows the summary of the selected literature reviewed that conducted on subjective experiences in mental health care services in other countries and in Malaysia.

**Table 2.5:** Summary of Selected Reviewed Studies on Subjective Experiences in Other Countries and in Malaysia

<b>Literature Review on Subjective Experiences in Other Countries</b>		
<b>Study References</b>	<b>Objectives</b>	<b>Findings</b>
<b>Gilburt, Slade, Rose, Lloyd-Evans, Johnson, and Osborn (2010)</b>	To explore patients' subjective experiences of traditional hospital services and residential alternatives to hospital in UK	10 main themes: Opinions about the services, relationships, patients, coercion, freedom, paternalism, safety, activities, treatment, and environment
<b>Johnson et al. (2004)</b>	To investigate and compare women's experiences of admission to a women-only crisis house and to general acute wards	Themes: safety and fear of other services users, benefits of the company of other service users, effects of the crisis house and hospital environments, the stigma of admission, contact with staff and opportunities to talk, involvement in care, management of medication, other treatments and activities, women with children, and assessment and admission,
<b>Osborn et al. (2010)</b>	To compare patient satisfaction, ward atmosphere and perceived coercion in the residential alternatives to acute in-patient care in England	Service users from alternative service reported greater levels of satisfaction compared with standard wards. On the Admission Experience Survey (AES), service users in alternatives perceived less coercion and having more "voice". Greater autonomy, more support and less anger and aggression were revealed by the Ward Atmosphere Scale (WAS) score.

**Table 2.5** continued

<b>Literature Review on Subjective Experiences in Malaysia</b>		
<b>Study References</b>	<b>Objectives</b>	<b>Findings</b>
<b>Low and Lee (2015)</b>	To investigate the problems encounter by mentally ill patients on the services provided by caregivers in a community-based rehabilitation centre in Malaysia	Two dominant themes were identified from the data analysis: Need for caring, respectful and understanding caregivers, Need for trained caregivers
<b>Low, Lee and Jacob (2017)</b>	To investigate the psychological distress faced and experienced by the residents in a community-based rehabilitation centre in Malaysia	Four main themes emerged: Need of family support, the need to preserve integrity, lack of understanding and stigmatization, desire for social acceptance

## **2.5 Feminist Perspectives**

This study focuses on the feminist perspective that promotes gender equality and social justice as a guiding framework in exploring and understanding the experiences of women with mental health problems. Feminist perspectives develop a theoretical understanding of the women's position (Orme, 2009) and concerns that affect women within women's lives (Gary, Sigsby, & Campbell, 1998). In the feminist perspectives, women are oppressed in many ways through social, political, and economical subordination (Angelique & Culley, 2003) and thus it values the women's experiences and ideas, as well as emphasizing the equality between men and women (Matlin, 2012). Using these feminist perspectives, it provides the framework in understanding how oppression of women in the society shaped the women's experiences in the care centre since feminism theorizes that women's experiences shaped by gender that cannot separate from the women's life



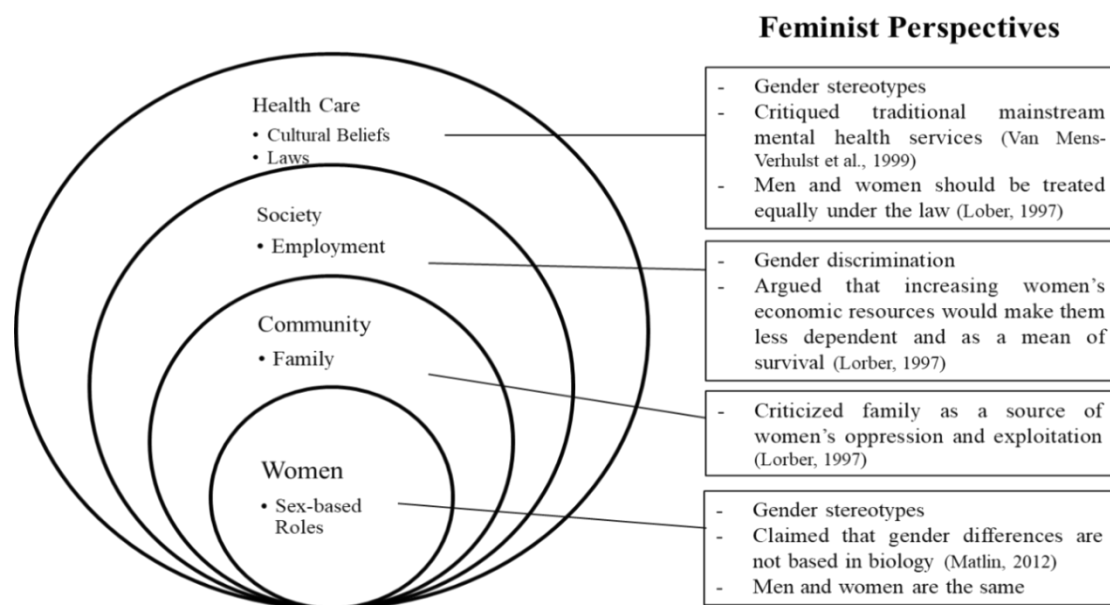
experiences contexts and identities (Bond & Mulvey, 2000). Thus, feminist perspectives will facilitate a better understanding of the participant's experiences.

An individual and his or her environment is interdepending for life development as proposed by Bronfenbrenner in his ecological perspectives argued that one's social interaction with different levels of environmental factors affecting one's development (Bronfenbrenner, 1994). A woman's experiences are understood relating to their social interaction with different levels of environmental systems as identified by Bronfenbrenner (1994) such as gender, family, social and political circumstances. For example, women and men in a family household have different responsibilities and tasks for maintaining a home and daily living (Pilcher & Whelehan, 2017). Women are assigned various roles in the family such as the caregiver, the nurturers, the educators, the source of stability, and income contributors (O'Connell, 1994), while men have greater power and authority in household decision making which views men as the breadwinner and head of the family (Sultana, 2011). Men also have a higher position than women at every level in society such as in health care, education and employment, as well as laws governing marriage, divorce, property ownership and inheritance (O'Connell, 1994). This interaction would lead to harmful and discriminatory practices, as well as violence against women (O'Connell, 1994) such as rape, sexual harassment, women battering and reproduction (Swift, Bond, & Serrano-Garcia, 2001).

Moreover, religion and culture that shaped the value system and the social organization norms in most societies play a role in defining women's position because most major religions (e.g., Christian, Hinduism, Islamic, and Buddhism) see women in a secondary position in relation to men (Noor, 1999). Hence, the hierarchical and patriarchal family structure, the women's subordination field, and the gender roles discriminatory

designs have drawn attention from feminist views (O’Connell, 1994). Feminists argued and believed that a male constructed society is directed by men for the benefit of men and thus a woman’s experience is considered secondary to a man’s and many women’s roles are devalued (Jebali, 1995).

Anderson (2010) points out that feminism is the principle that values women’s experiences and ideas, as well as emphasizing social, economic and social equality among women and men. Feminism refers to the efforts to end women’s subordination (Jaggar, 1983) through variety of ideas and perspectives that explained the oppression (Rozee et al., 2008 in Matlin, 2012) such as liberal feminism, Marxist feminism, socialist feminism, radical feminism, and postmodern feminism. Feminism also seeks to empower women and challenges the gender-related stereotypes since it accepts that gender is socially constructed and understand that power imbalance stemming from it. Figure 2.3 shows an adapted ecological model and feminist perspectives explaining the oppression.



**Figure 2.3:** Adapted Ecological Model and Feminist Perspectives  
(Source: Bronfenbrenner, 1994)

Although the feminism movement in Malaysia is similar as in other countries has the same goal for women to be treated economic, political and social equally, Malaysians do not like to be labelled as feminists due to the misinterpretation of feminism concept that contains western elements and is seen as irrelevant to local conditions (Ariffin, 1999; Lee, 2018). However, feminism has many variations in Malaysia that can be understood differently and embraced by the society within the same historical moment which are not basically a manifestation of changing history, but at least an ideology that challenges power, ranging from colonial systems to patriarchal cultural orders and state regulation, and the ethnic and cultural backgrounds (Ng, Mohamad, & Tan, 2006). The four dominant feminisms in Malaysia's history are nationalist, social, political, and market-driven which often overlaps more than one historical period and are a mobile and continuous movement (Ng, Mohamad & Tan, 2006).

Nationalist feminism is the first phase where women struggled for national autonomy such as rights in education and in legal system, while social feminism is the second phase where women sought for equal rights in employment and in voting (Ng, Mohamad, & Tan, 2006). Political feminism as the third phase of feminism evolution in Malaysia involving the implementation of the New Economic Policy (NEP) since new conceptual ideas such as the terms "women's subjugation" and women are "second sex" were introduced to revisit the roots of gender inequality, whereas the market-driven feminism is the fourth phase which see women are still opposed by a variety issues such as the demand for political and economic equality, but their participation in the job market gives them the power to consume has contrasted to the situation (Ng, Mohamad, & Tan, 2006).

Malaysian feminism has gone beyond its original meaning from fighting for women's rights and legal reforms in education, property rights and voting rights extended to

the awareness and analysis of women's discrimination and exploitation in the family, at work, and in society, as well as all conscious efforts that wish to end gender inequality (Ng, Mohamad, & Tan, 2006). Feminism not only rejects any gender suppression in politics, economy, or social, but also prompts the need to explore about the gender issues in society (Zahar & Hussein, 2013). Hence, feminism movement in Malaysia have paid more attention to women issues due to the rise of violence against women in the 1980's such as domestic violence, rape, and sexual misconducts since women are stereotyped as having limited roles and highly depended on men which has marked the establishment of women's non-governmental organisations (NGO) (Ariffin, 1999).

The Women's Aid Organisation (WAO), All Women's Action Society (AWAM), and Sarawak Women for Women's Society (SWWS) were some of the groups that developed to help women and question the causes and reasons of violence perpetrated on women in society (Ariffin, 1999). The underlying principles and philosophy behind the formation of these women's groups were not to restrict their activities to extending social services to abused women but introduce a new ideology of feminism in understanding the concept and origin of women's oppression to discover the reasons and causes of women's victimization when exposed to violence (Ng, Mohamad, & Tan, 2006).

Therefore, feminism exist in Malaysia in different variations to advocate for the women's rights, promote gender equality and social justice. Although there is no standard definition of what feminism really means within the Malaysian context, but it can be understood based on the liberal, humanistic, and socialist perspectives of justice and equality, as well as someone who believes in the objectives of gender justice, work within the paradigms, and have the intention of informing justice for women are feminists (Ng, Mohamad, & Tan, 2006). Hence, political feminism was appropriate and chosen in guiding

this study since political feminism believes that patriarchy as the root cause of women's oppression and inequality and of gender-biased laws and thus fight for women's protective ways and the harmful manifestations of patriarchy in family, society, laws, and women health care.

### **2.5.1 Feminist Perspectives in Women's Health and Mental Health Care**

Gender differences in mental health problems relate to biological and psychosocial characteristic (Doucet, Letourneau, & Stoppard, 2010). According to Matlin (2012), sex and gender are two key terms in women's psychology where sex refers to biological characteristics related to reproduction, while gender refers to psychological characteristics. Biological factors such as differences in hormone levels, neurotransmitter levels, and endocrine regulatory system (e.g., menstruation, pregnancy, childbirth, and menopause) placed women at higher rate for mental health problems than men (Blehar, 2006; Piccinelli & Homen, 1997). While, psychosocial issues such as women's roles in society (e.g., their primary responsibility as care takers in the family and worker outside home), as well as gender discrimination and other forms of violence that are faced by women (e.g., rape, domestic violence, sexual harassment, achievement, work, sexuality, and retirement) (Doucet, Letourneau, & Stoppard, 2010; Matlin, 2012) also can negatively affect a woman's mental health and contribute to the high prevalence of mental health problems experienced by women (Doucet, Letourneau, & Stoppard, 2010).

Moreover, the mental health effect is different on Malaysian women's roles because cultural and religious values further reinforce and emphasize on their family role rather than at the workplace (Noor, 1999). The contemporary Malaysian women's position is unique because they are not only responsible for the home and children, but also engaging in employment which affects their mental health (Noor, 1999). Furthermore, a Malaysian

woman's status was perceived as lower than that of man has led to sexual inequality by excluding women from important economic and political activities and inhibited by the strong cultural beliefs that women must take the primary role at home and second place to men at the workplace (Noor, 1999). For example, men have always been the head of the household and one step above women, but women on one hand has to abide by the traditional cultural and religious values, on the other hand, they are demanded to be assertive and independent and have a say in running the household contributed to their mental health well-being (Noor, 1999).

Psychologist has thus emphasized psychological issues on gender differences in mental and emotional problems imbedded within a feminist framework (Mowbray, Herman, & Hazel, 1992) since gender stereotypes affect women and their experiences of mental illness and the designed health care services (Wright & Owen, 2001). Since living in a male dominated society where power relations related to gender roles and mental illness, women who experienced mental health problems are more vulnerable to oppression (Doucet, Letourneau, & Stoppard, 2010). Therefore, feminist perspectives examine how environmental influences such as social, political, economic, ethnic, and cultural factors influence women's mental health and illness experiences (Doucet, Letourneau, & Stoppard, 2010), and examine how these environmental influences have shaped women's lives, knowledge, opportunities, and choices through women voices (Anderson, 2000).

Since women's issues and concerns are affected by inequalities and injustice that exist in a patriarchal structure which is the major theme that forms the feminist perspectives (Gary, Sigsby, & Campbell, 1998), feminist concepts that are applicable to women's health and health care aims to change how health care is provided to women and to seek social transformation (Andrist, 1997). The important feminist concepts in improving women's

health and health care involve listening and responding to the women's life experiences (Lauver, 2000), changing existing structural power relations in society (e.g., provider-patient relationship) (Andrist, 1997), encouraging women's control in health-related decision and respect women's choice (e.g., shared decision-making), developing women's inner wisdom (e.g., information accessibility), and creating an environment for transformation and empowerment of women (e.g., social change) (Lauver, 2000).

Moreover, feminism mental health care has critiqued the traditional mainstream mental health services misrepresents, unequally treats and unjustifiably pathologizes women, and has shifted from a predominantly illness-oriented form to emphasizing the client's well-being (Mens-Verhulst et al., 1999). Hence, the feminist psychologists have offered new psychotherapy concepts to improve mental health care (Draganovic, 2011) on personal level is political (e.g., social change needed), egalitarian relationship (e.g., equality relationship between a client and therapist), honouring women's experiences (e.g., not dismissing or discarding as of lesser value), reformulate distress and "mental illness" definitions, as well as integrated oppression analysis (Sommer-Flanagan & Sommers-Flanagan, 2004), emphasize client's role and expertise that encourage social change, viewed problems within wider socio-political and cultural context, and to challenge traditional psychological health assessment ways that assumes individual change best occurs through social change (Sharf, 2012). In short, feminism advocates gender equality in society and in health care services. Therefore, feminist perspectives were chosen in guiding this study to understand the experiences of women with mental health problems staying at a care centre.

## **2.6 Conclusion**

The definitions of mental health and mental health problems are reviewed in this chapter. The medical model is usually used by health professionals in defining the mental

health problems based on the medically accepted classification systems. However, due to the multi-cultural and multi-ethnicity in Malaysia, Malaysians perceived mental health problems differently due to the influence by their cultural belief systems. This is then affected the Malaysian help-seeking behaviour although formal health care services existed in the form of primary care, community-based, and hospital-based. The experiences of people with mental health are also reviewed and discussed. In order to understand the experiences of women with mental health problems in this study from women's voices, feminist perspectives were chosen in guiding this study.



## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

This chapter will discuss about how data is collected and analysed. The data is collected using a qualitative approach with face-to-face and in-depth interview. Criteria for selection of the research participants, the research site, data collection and analysis procedure are discussed below. Moreover, the insider's view, ethical considerations, and limitations are also discussed.

#### **3.1 Research Methodological Framework**

Qualitative research methods underpinning social constructivism approach (often combined with interpretivism) was used in this study. As in social constructivism, individuals construct subjective meaning of their experiences through the world they engage with and interpret based on their historical and social perspectives (Berg, 2004; Creswell, 2014). This study aims to understand the experiences of women with mental health problems that led them to be admitted to the centre and the experiences of staying at the care centre in Malaysia. Thus, the researcher seeks to understand the participants' context through visiting the context and gathering information personally interpreted by them which was shaped by their own experiences and background (Creswell, 2014). Through qualitative method, it provides the researcher an opportunity to listen to respondents' life experiences, respect respondents' local meaning and interpret respondents' opinion and stories to yield rich and universal data (Tracy, 2013). Moreover, qualitative research is highly inductive where the meanings generate or interpreted from the data collected in the field, not the researcher's meaning (Berg, 2004; Creswell, 2014). However, constructivism was also coined to highlight the importance of subjectivity and reflexivity (Padgett, 2017).

According to Sprague and Kobrynowicz (2004), feminist epistemology implies that the relationship between the knower and the object of knowledge are dialectical when producing knowledge. Truth is the outcome of the free, conscious and intention acting of the world which will be attained after eliminating the conflicts (e.g., background assumptions and ideas) between the subject and object (Sprague & Kobrynowicz, 2004). In order to do this, the conversation between the subject and object must be structured strategically as a critical dialog through listening to and learning from the perspectives of various subjects and diverse scholars (Sprague & Kobrynowicz, 2004) and thus it calls for qualitative enquiry which is less structured and more flexible than that of positivist science (Liamputtong, 2009). Angrosino (2007) mentioned that the feminist research aims to “capture women’s living experiences in a respectful manner that legitimates women’s voices as a source of knowledge”. Since this study was guided by feminist perspectives, the experiences of women and their concerns are the focus of investigation in the feminist methodology.

Feminist methodology adopts qualitative methods (Campbell & Wasco, 2000) often employs data collection methods in qualitative approaches such as in-depth interviews, focus group discussion, ethnography, and narrative (Angrosino, 2007) to provide a non-hierarchical research environment (Berg, 2004) and try to strengthen the connections between researchers and participants (Liamputtong, 2009). Therefore, the subjective experiences of the women with mental health problems in the selected care centre were explored through a qualitative research method. Feminist research also involves thinking and feeling and thus feminist methodologists advocate reflexivity as it provides insight and critical analysis of the research process (Campbell, 2002; Fonow & Cook, 1991). Apart from this, reflexivity also helps to address concerns about unexamined power balances between

researcher and participant when the researcher is self-aware of the research process to produce more accurate interpretations of the participants (Finlay, 2003).

Hence, qualitative method is suitable to be used in this study as it allowed the researcher and the research participants to express their feelings and experiences in their own words since the nature of qualitative research designed to be flexible and fluid that encourage free and unambiguous disclosure (Liamputtong, 2009). If the study is a quantitative research, the researcher and the research participants are unable to talk about their feelings and give meaning to their life stories, and thus are unable to interpret their experiences in their own words (Liamputtong, 2009). Thus, Creswell (2014) mentioned that it is better to keep the questions open-ended to allow the participants to construct their meanings of their life stories from their own words.

In addition, qualitative methodologies have been used within the mental health research because it provides a technique of giving voices to participants and offers an effective way of involving services users in developing intervention by ensuring that the questions asked are meaningful to individuals (Peters, 2010). In mental health research, the researchers used qualitative approaches in understanding the subjective experiences of the people with mental health problems, the social, cultural and political factors to these experiences, and interaction of the service users with the mental health system besides developing knowledge, improving validity, and evaluating the quality of research (Fossey et al., 2002). Therefore, qualitative data of this study was collected through qualitative method by using in-depth interview.

Hox and Boeije (2005) described qualitative data as data involving understanding of the research subject's complexity, detail, and context in the form of texts, such as interview transcripts, field notes, or audio-visual material. Moreover, qualitative data allows

researchers to focus on how people learn about and make sense of themselves and others, as well as how they structure and give meaning to their daily lives (Berg, 2004; Hox & Boeije, 2005). The source of primary data in this study is the in-depth interview with the women with mental health problems in the care centre in Malaysia. Primary data was chosen in this study as the original data collected for a specific research goal (Hox & Boeije, 2005). Hence, the unfolded social reality in qualitative data enables me to capture the participant's subjective experiences.

### **3.2 Research Location**

This study is carried out at a care centre situated in Perak, Malaysia. Approval has been obtained from the centres' management team before entering the field. The selected care centre is one of the most established mental health referral centres in Malaysia which treats and cares for people with psychiatric disorders (Ipoh Echo, 2010). The centre was selected because it accommodated a few female residents with different ethnic groups who have been diagnosed with a mental health problem and are currently being treated by a psychiatrist.

The centre located at Perak, Malaysia. Perak is one of the 13 states in Malaysia located on the west coast of the West Malaysia (Perak for Tourists, n.d.). Perak is just adjacent to the Kedah and Penang states and is the north of Selangor (MyMalaysiaBooks, n.d.). Perak Darul Ridzuan, the Land of Grace, covers an area of 2100 square kilometres and has a population of about 2 million (Cuti.my, n.d.). There are 9 districts in the state where Ipoh, Kuala Kangsar, Taiping, Teluk Intan and Lumut are the major towns, while Kuala Kangsar is the royal town of Perak and Ipoh is the administrative centre and state capital (Cuti.my, n.d.).

The centre was founded by a consultant psychiatrist of Hospital Bahagia in October 1969 who suggested a pilot project of a rehabilitation programme for the emotionally disturbed individuals and medically cured mental patients (Ipoh Echo, 2010). Later, the centre had undergone various changes and finally the Perak State Government gave the Society 12 acres of land at Jalan Tambun, Ulu Kinta to establish a permanent centre for the rehabilitation of mental patients in the year 1978. In year 1984, an administrative block, a work area, a kitchen and dining area, stores and sundry rooms, and four chalets were built (Ipoh Echo, 2010). This centre was declared open by DYMM Paduka Seri Sultan Azlan Shah at 1985 and the reign of the Society was taking over by Dato Dr Majumdar, the president of the centre from 1986 (Ipoh Echo, 2010).

The centre was managed by an administration team consisting the centre supervisor, assistance supervisor, administrative staffs, rehabilitation staffs and other staffs. According to the centre supervisor, it is run daily from Monday to Friday from 9am to 5pm, and there is a small monthly fee collected to partially cover the costs of the programme (refer to Appendix F). The centre provides counselling, social and occupational rehabilitation services to people with mental health problems to help them to reintegrate into their community, recover from the symptoms, and help them to gain and develop skills and resources necessary to live in the community. According to the centre rehabilitation staffs, various activities were introduced to rehabilitate the residents such as singing, dancing and various occupational therapeutic activities. Various facilities are also provided for the residents and families such as a sheltered workshop, recreational hall, residential chalets, library, hair saloon, ceramic and handicraft production, orchid nursery, and a vegetable garden for farming. The centre worked closely with hospital-based psychiatrists at the mental

hospital, general hospitals and clinics to provide medical supervision and health screening to improve the residents' health status and well-being.

Nevertheless, as pointed out by the president of the research site, the selected centre is a Rehabilitation Centre rather than a Community Mental Health Centre because it was not covered under the Mental Health Act 2001 and thus not recognised by the MOH (Jeyaraj, 2014). The Mental Health Act 2001 (2006) stated that, under section 32, a community mental health centre *“is a centre for community care treatment which includes the screening, diagnosis, treatment and rehabilitation of any person suffering from any mental disorder”*, but the centre only provided treatment and rehabilitation. Moreover, under section 37(3) of the Mental Health Act 2001 (2006), *“the community care treatment referred to in subsection (1) and (2) shall be provided on an outpatient basis, and no patient shall be lodged in any part of a community mental health centre for more than twenty-four hours”*, however the centre accommodated the women residents who come from different states.

### **3.3 Research Participants**

This study employs purposive sampling which is a type of sampling techniques in non-probability sampling, in choosing the participants. The reason of using this technique because the participants are chosen purposively who are relevant to the research title (Hall, 2008). As this study focuses on the women with mental health problems towards their experiences that leading them to be admitted to the centre and experiences of staying at the care centre. Therefore, the sampling frame of this study was focused on the women with mental health problems in the selected care centre. The selected women were diagnosed with mental health problems such as Schizophrenia, Depression, and Bipolar Disorder, and able to communicate and in a stable condition such as having less relapse and not under supervision of rehabilitation staff as recommended by the centre supervisor. The inclusion

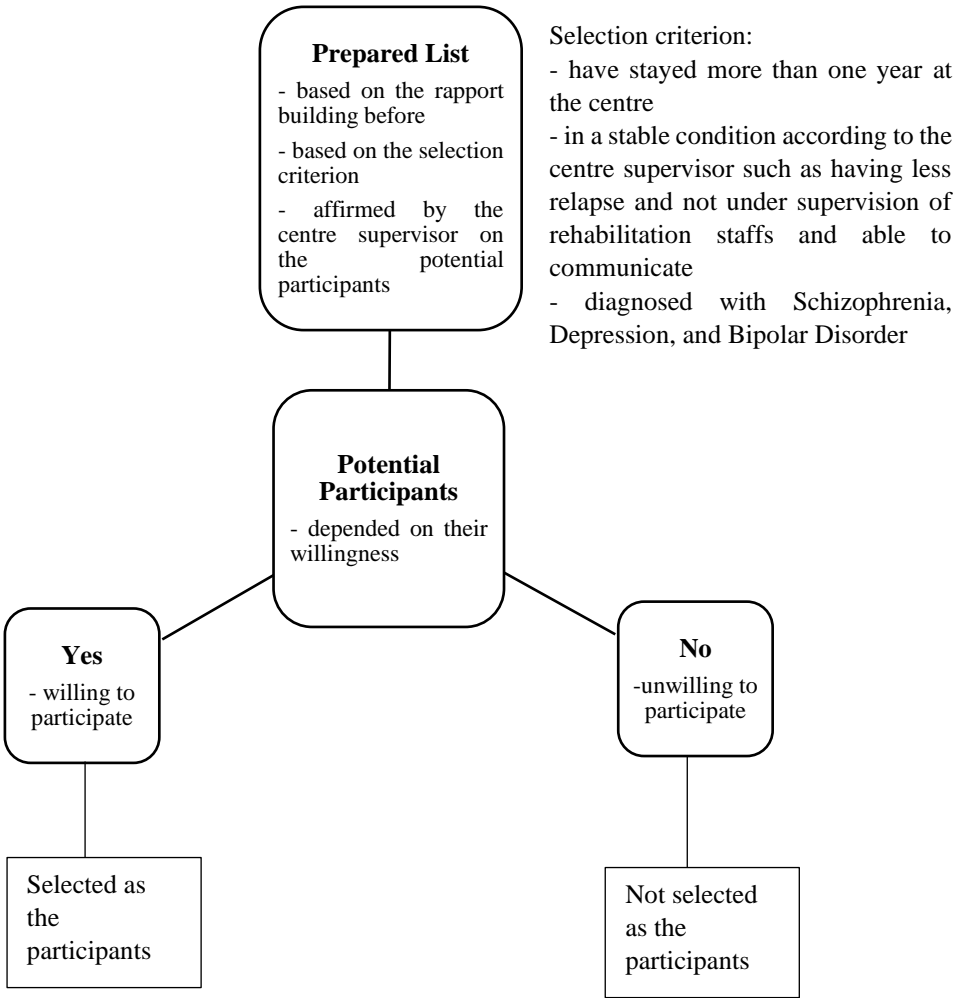
criteria for this study was mainly based on their years of staying at the selected care centre to provide their subjective experiences that leading them to be admitted and stayed at the centre.

According to the centre's supervisor, the centre accommodates about 90 full-time women residents from different ethnic groups, religious, and age ranging from above 20 to 80 years old. The Chinese is the largest group which makes up 90% of the population in the centre followed by the Malays and Indians. Majority of the women residents have been diagnosed with mental health problems such as bipolar disorder, depression, and schizophrenia. Only female clients who are recommended by psychiatrists are accepted as day patients or residents, and male clients may be accepted as day patients to learn new skills in the centre.

Upon obtaining approval for entering the field, the researcher requested the residents list from the centre supervisor to affirm the residents who are capable in participating in the study to exclude those who are unable to communicate or are in acute condition such as those having regular relapse and still under supervision of rehabilitation staffs. I knew some potential participants during my industrial training as a social work student at the selected centre and thus have selected them based on the inclusion criteria after affirmed with the centre supervisor. The participations of the selected participants were mainly depended on their willingness. It was sad to hear that some of the residents in the list had passed away, but at the same time it was happy to know that some of them have been discharged from the centre and are now back to their homes.

However, some potential participants might be left out from this study due to their discharge from the centre. In order to listen to more women to tell their life stories and to yield more rich and complex data, I was suggested some newly admitted residents by the

centre supervisor who were chosen based on the selection criterion on the years of staying at the centre. Before the interview, I also have reaffirmed with the residents on their willingness to participate in the study. Figure 3.1 shows the sample selection process.



**Figure 3.1:** Example of sample selection process



**Table 3.1:** Participants' Social Demographic Background

<i>Participant (Pseudonym)</i>	<i>Age</i>	<i>Marital Status</i>	<i>Education Level</i>	<i>Religious Affiliation</i>	<i>Origin</i>	<i>Length of Stay (years)</i>	<i>Diagnosis</i>
Ms. Koh	48	Single	University	Buddhist	Penang	3	Schizo- phrenia
Ms. Cheng	42	Single	Form 3	Buddhist	Perak	8	Schizo- phrenia
Mrs. Hong	56	Married	Form 3	No Religion	Penang	3	Schizo- phrenia
Mrs. Sim	44	Married	Polytechnic	Christian	Penang	8	Bipolar Disorder
Ms. Tan	42	Single	Form 1	Christian	Perak	6	Depression
Ms. Sandy	63	Single	Form 5	Christian	Melaka	9	Depression
Ms. Chai	57	Single	Form 5	Buddhist	Perak	21	Schizo- phrenia
Ms. Hoon	42	Single	University	Christian	Perak	1.5	Depression
Ms. Lai	38	Single	Form 3	Christian	Perak	6	Bipolar Disorder
Ms. Woon	57	Single	Form 3	Christian	Perak	10	Bipolar Disorder
Ms. Ee	42	Single	Form 3	Christian	Perak	2	Schizo- phrenia
Ms. Boon	63	Single	Form 3	Buddhist	Tereng- ganu	35	Schizo- phrenia

(Source: Interview guide, Section 1)

Chinese residents were the only one involved in this study because only this ethnic group agreed to participate in this study whose age ranged from 30 to 65 years old. Among the twelve participants, ten of them are single and the remaining two are married (refer to Table 3.1). The participants' background will be further discussed in Chapter 4. The participants are able to communicate and are in a stable condition according to the centre supervisor. Those with chronic conditions and those who are unable to communicate have been excluded from the study. The participants were diagnosed with mental health problems by the psychiatrists with six of them having schizophrenia, three of them having depression, and the remaining diagnosed with bipolar disorder.

However, I was aware that by using purposive sampling, the researchers only selected subjects who represent the population (Berg, 2004), not all the women with mental health problems in the care centre in Malaysia were being selected for this study and there was the study's selection criteria for recruitment of the potential participants (Padgett, 2017) and based on volunteer participation (Yegidis & Weinbach, 1991). In considering the sample size issue, I had ensured that the selected participants were best help in understanding the research problem and the research question to the point that no new information or themes are observed in the data or the concept of saturation (Creswell, 2014; Guest, Bunce, & Johnson, 2006). Hence, 12 participants were recruited for this study.

### **3.4 Data Collection Process**

The participants' experiences are the main source of information for this study. The data were collected through the qualitative approach of face-to-face in-depth interviewing with the women with mental health problems. Liamputtong quoted Kvale's work (2007) that defined interview is a special conversation form to produce knowledge through the interviewer's and interviewee's interaction (2009, p.42). In-depth interviews are often

adopted in qualitative mental health research (Liamputtong, 2009) to seek participants' views on topics of interest (Fossey et al., 2002; Gill et al., 2008; Peters, 2010), to listen to their life stories (Peters, 2010), and to gain access to their experiences, feelings, and social worlds (Fossey, et al., 2002). Through in-depth interview, I was able to find out their thoughts, perceptions, feelings and experiences that captured in the participants' own words.

The semi-structured interview was carried out guided by an interview guide (refer to Appendix A) to facilitates a more focused exploration of specific topic that put in a focused, flexible and conversational manner (Fossey et al., 2002). The developed interview guide contained open-ended questions that allow the women to talk freely about their experiences in their own words (Liamputtong, 2009) that based on the research objectives (Berg, 2004) to achieve depth understanding (Fossey et al., 2002). The use of interview guide allowed the researchers to have clear ideas to access to the information they want and reflect their research aims (Berg, 2004). According to Liamputtong (2009), the interview process required active asking and listening to seek depth understanding and information from the participants that began with a rapport building between researcher and participant.

Before entering the field, approval has been obtained from the centre's president to visit the centre and to conduct interview with the participants. All the required documents such as the permission letter from the researcher (refer to Appendix B) and the university (refer to Appendix C), and the consent letter contained in the research statement (refer to Appendix D) have been well prepared. Once approval (refer to Appendix E) was obtained from the centre's president, the researcher entered to the field. The researcher has asked for the potential participants and available places for conducting the interview from the centre supervisor.

Later, the researcher started the interview session after confirmed with the potential participants and place. The interview sessions were conducted with participants once at the centre's workshop or dining room because the residents spent most of their time there to carry out their rehabilitation and occupational therapeutic activities. The participants were interviewed during activity time because they need more time to rest after taking medicines. Thus, the researcher is only able to interview one or two participants in a day. The interview was conducted in English and Chinese languages. However, most of the participants choose to communicate in Mandarin even though most of them able to communicate in English because Mandarin is their mother tongue. Only one participant used English throughout the interview session because she felt comfortable speaking in English. Each interview session has been carried out for about 40 to 60 minutes. The interview has been conducted from January 2017 to March 2017.

Before starting the interview, the researcher sought permission from the participants to be voice recorded the interview session. Most of the participants allowed the recording with one exception and in order to respect the participant, the researcher wrote down the important points throughout the interview session. In accordance with the research ethic - informed consent (Vanclay, Baines, & Taylor, 2013), the participants should participate voluntary and have enough information and adequate understanding of the research as well as the consequences of their participation. Before the interview started, the researcher explained the research aims to the participants and a research statement was prepared and given to the participants. To record the informed consent, the participants were asked to sign the consent letter if they decided to partake in the interview. The researcher also stayed beside the participants to help those who are unable or have difficulty in reading to understand the research and to explain verbally if needed.

After understanding the research aims and decision to participate in the research, the face-to-face in-depth interview guided by an interview guide started with the participants' demographic backgrounds. I also gave a brief introduction of myself as part of the process of building mutual trust and enhancing rapport between the researcher and participants to give the researcher opportunities to gain insight to their experiences and encourage the participants to elaborate on their subjective experiences (Liamputtong, 2009). The demographic questions were relatively straightforward to be answered by the participants to help readers to have a brief understanding on the participants. Next, the interview moved towards more in-depth questions on their experiences before and after being admitted to the centre. Towards the end of the interview, I verified with the participants whether they have any further points to make and gave them opportunities to ask questions during the interview, if they choose to do so. The data collection came to the end when saturation has been achieved such as when the data show redundancy and no new information (Padgett, 2017).

Some of the interview sessions did not follow the sequence of the interview guide, as they were sharing more about their personal experiences before admitted to the centre. One of the questions regarding the onset of mental health problems related to cultural and belief system was developed after the second interview session since the participant mentioned that and later the question was asked in the following interview session. When the participants were talking about another aspect of their experiences beyond the key questions in the interview guide, I would go with the flow and came back later to the interview guide to allow to draw out more of their experiences. The participants have freely expressed their point of views during the interview, but at the same time the researcher remain focused on the research topic (Liamputtong, 2009). Few interview sessions were interrupted when the participants disclosed their personal stories and thus flexibility is

needed. For example, one participant was crying, and another participant requested to stop during the interview session when sharing their experiences. According to Liamputtong (2009), the participant may cry, the researcher should prepare to offer comfort when conducting research with vulnerable groups and need to be patient and wait for the participants to give response. Thus, I stopped the interview session to avoid harming the participant and offered comfort to the participant. I anticipated that and asked for the participants' permission to continue the interview to affirm their willingness to continue sharing their experiences. All the chosen participants participated willingly in the study.

### 3.5 Data Transcription and Analysis

The audio recorded interview gathered through face-to-face interviews were organised and stored in a folder after each interview. All the data were backed-up in an external USB drives to prevent data loss due to unexpected incidents. Each of the recordings was labelled with unique codes to maintain the participant anonymity. Through specific notations of each interview session (refer to Figure 3.2), I was able to access them easily for my transcription, analysis and writing-up of my findings. Figure 3.2 shows the code formation.

Code: _____ - _____ - _____ Name                    Age                    Diagnosis  Example: Koh_48_SZ	<b>Diagnosis:</b> Schizophrenia - SZ Depression - DP Bipolar Disorder - BD
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**Figure 3.2:** Example of coding for recorded audio

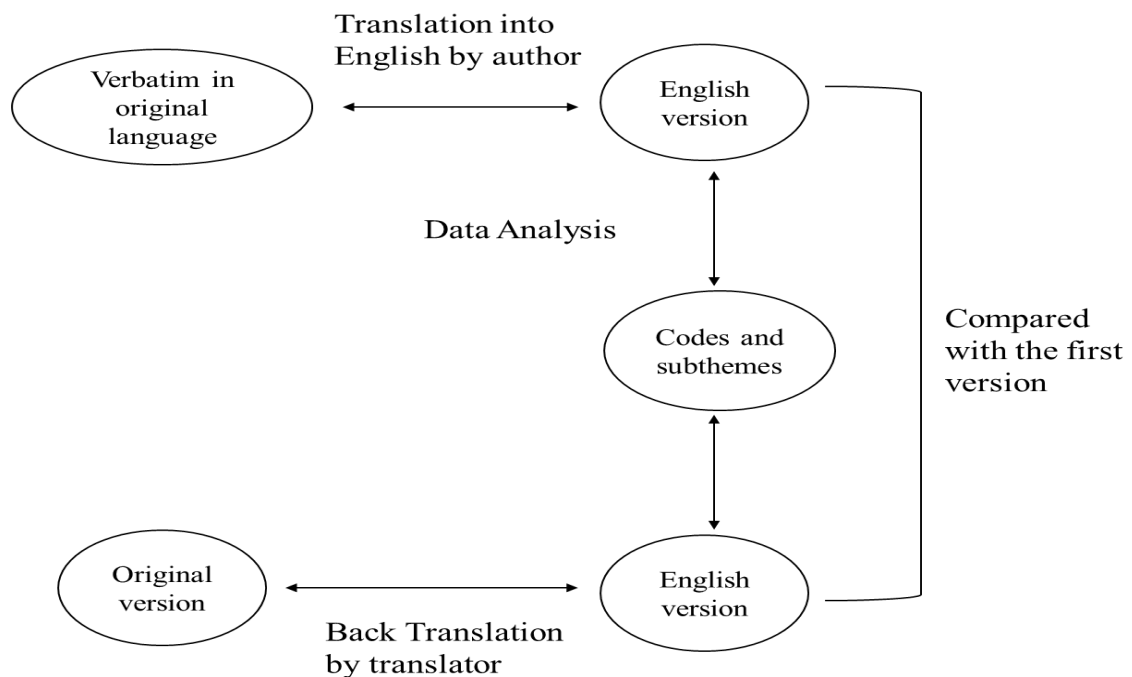
After that, the audio recorded interviews with the participants were transcribed into textual data as soon as the interview session ended. When every first transcript was

completed, I checked the transcripts twice by reading through the transcribed recordings while listening to their original audio to make sure no obvious mistakes were being made during transcription based on the file as necessary for authenticity assurance and reliability of the data (Creswell, 2014). The transcripts were translated into English as close as possible to capture the meaning later during analysis. Certain features of talk such as tone and expressions are transcribed by using transcription key (refer to Appendix G) to enable me to examine data closely, but some words or idiomatic phrases I do not translate, put in italics, and explain the meanings in brackets (Padgett, 2017; Powick & Tilley, 2002; Speer, 2008).

The transcripts were then sent to a translator for back-translation which is a translating process of a document (e.g., transcripts) from the target language (e.g., English) back to the original language (e.g., Chinese) until it makes sense in both languages (Chen & Boore, 2010; Li, 2016) to validate the findings (Chen & Boore, 2010; Creswell, 2014) and to reduce the researcher's bias (Padgett, 2017). The transcript format was showed in the Table 3.2. It is divided into three columns and two rows. Each table is labelled with the recording codes. The main questions were in the first column; while the follow-up questions were put in second row to enable ease of reading. Then the transcribed recordings in the middle column tally with the questions in the first column. The third column is the codes, notes making, queries, and comments. Figure 3.3 shows the translation and back translation process.

**Table 3.2:** Example of interview excerpt of Koh\_48\_SZ

Would you like to share with me about your experiences of admission to the centre?	I have stayed here for three years. I feel okay. Ah <sup>10</sup> ... The food is okay. Everything is nice la. But sometimes people get violent here. Ah... I stayed quiet la. When I first come is better la. And maybe I get to know them, they are moody, but I okay la. I keep quiet la.	Years of staying  Everything is fine
Do you know how you are coming to the centre?	Oh. I come here because I didn't take medicine for a few months. My father sent me here. My father died and that's why my sister send me here la. Ah...Ah...	Reason of admission
Do you know why your sister send you here after your father died?	My sister is too busy. Ah... too busy la.	



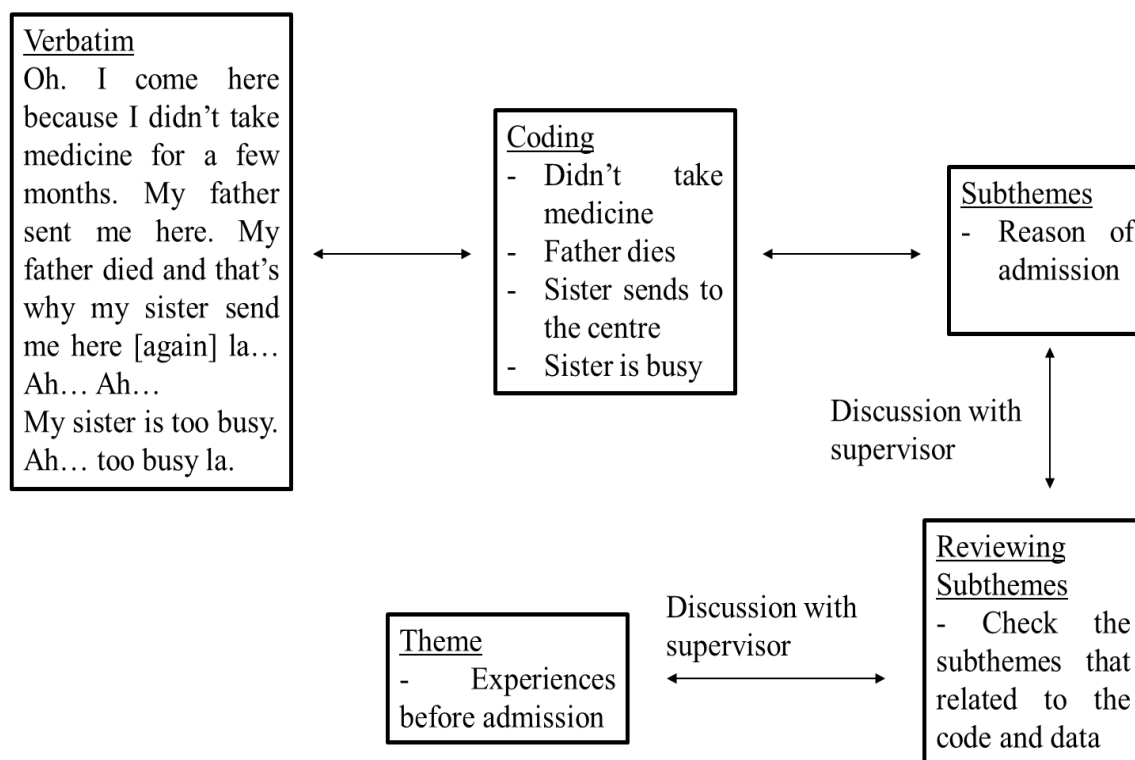
**Figure 3.3:** Example of translation and back translation process  
(Source: Chen & Boore, 2010)

<sup>10</sup> Refer to Appendix G for the transcription key used for coding in this study.



Thematic analysis was chosen as the data analysis approach for this study to emphasize and understand the subjective meaning of experiences of the participants which is the common approach used (Peters, 2010) that focuses on developing categories and deriving inductive data to enable systematic description (Fossey et al., 2002). The reason of choosing thematic analysis because it is highly inductive since the themes are emerged from the data collected instead of imposed by the researcher (Carey, 2013). Creswell (2014), Braun and Clarke (2006) explained that data analysis in qualitative research is a recursive process instead of a linear process that requires moving back and forth throughout the analysis process which is time-consuming and should not be rushed to describe and explain the studied phenomena or social worlds (Fossey et al., 2002).

Moreover, thematic analysis is a flexible research tool to provide a rich and detailed data (Braun & Clarke, 2006) and a useful method to work with a wide range of research questions, analyse different types of data, work with large or small data-sets, and applied to produce data-driven or theory-driven analyses (Clarke & Braun, 2013). The six phases of thematic analysis included data familiarisation, coding, searching for themes, reviewing themes, defining and naming themes, and writing up (Braun & Clarke, 2006). The transcripts were analysed from March 2017 to June 2017. Figure 3.4 shows the process of developing themes.



**Figure 3.4:** Example of process of developing themes

In the first phase, the verbatim were first transcribed into English language and then into a written form for thematic analysis. The researcher read and reread the data collected by listening to the audio-recorded data to familiar with the data to develop an initial coding frame. In order to familiarize with the data, the researcher needs to check the transcripts back against the original audio recordings for accuracy (Braun & Clarker, 2006). Phase two begins to generate an initial idea about the data after familiarizing with the data by labelling the important features of the relevant data (Clarke & Braun, 2013). Then, different subthemes have been developed and identified from the codes. The identified subthemes were reviewed by checking the subthemes that relates to the code and data (Clarke & Braun, 2013). Subthemes and the themes emerged in phase three and phase four were discussed together with the supervisor based on the research objectives. The emergent subthemes were categorised into different themes and finally discussed in Chapter Four.

### **3.6 Ethical Consideration**

Ethical issues were raised when conducting research with vulnerable participants thus require careful consideration since qualitative research involves close interaction and relationship between the researcher and the participants, as well as the data collection method used (Liamputtong, 2009). Research ethics aims to ensure that the research process should not harm those who are being researched (Tew et al., 2006) and to ensure the rigour of the qualitative research (Liamputtong, 2009). Therefore, this study has considered the ethical issues such as voluntary participation, informed consent, confidentiality, and do no harm to avoid sensitivity among the participants when disclosing their personal experiences.

#### **Voluntary Participation**

Prior to the study, approval letter for entering to the field (refer to Appendix E) has been obtained from the gatekeeper to gain access to the selected centre and to participants. Since the study was carried out at a care centre, seeking permission accessing to research site and participants is a challenge in the research process to protect the vulnerable group, the women with mental health problems, or their families, and professionals from exploitation and free from coercion (McFadyen & Rankin, 2016). After gaining access to the centre, the centre supervisor provided me the latest residents' information to help to select potential participants based on the selection criterions.

However, I was still depending on the willingness and rapport built with the women for their participation in this study so that they are not feeling coerced into participating in the study (Berg, 2004; Creswell, 2014; Padgett, 2017). Although rapport with the participants was established previously, I found that there is pressure between the research space and participant's autonomy (Berger, 2015). The power differences between researcher and participants were obvious when a vulnerable group is involved in the interview (Berger,

2015) as the participants knew the role and purpose of the interviewer (Padgett, 2017). Hence, a verbal consent on their willingness for participation was informed to the women first before their participation in the study.

### **Informed Consent**

After agreeing on participation to the study, the interview session was started with informed consent to protect the participants' right to autonomy and to verify that participants have been fully informed of the purpose of the study and the potential risks associated with the study (Schub, 2016). The participants were initially informed about the purpose of the study, their rights, confidentiality, and the data collection method so that they can understand the study and can make a voluntary decision to participate (Berg, 2004). Before the study, a research statement (refer to Appendix D) about the nature of the study, objectives, and data collection method have been prepared in English and were given to the participants to read and understand the research purpose. Verbal explanations were also given to them for those who are unable or have difficulty in reading. The informed consent form was signed by the participants prior to the interview session once they understood the given information and agreed to participate.

Permission to audio tape the interview session was also obtained from the participants before or during the interview session. The interview session was not recorded if the participant disagreed to do so. The willingness of the participants was highly appreciated and thus they have been acknowledged at the time before the study, before the interview session and during the time of interview if they have a sign of discomfort (Saim, 2013). The participants have participated fully and willingly in the interview session and none of them withdrew from the interview.

## **Confidentiality**

Throughout this study, the confidentiality of participants' background information was guaranteed to safeguard the participants from harm that can come to them if their identities are purposely or unintentionally associated with any data collected (Yegidis & Weinbach, 2002). For example, the transcripts and recordings were kept in a personal computer and in a password-protected external USB drive, only accessible to the researcher (Berg, 2004). When analysing data and reporting findings, pseudonyms were used to protect the participants' right to privacy and to ensure that the information provided would not be manipulated and misused for personal purposes (Engelke, 2016). As a researcher with social work background, it is important to safeguard the participants' privacy and identity, for the research purpose and the social work ethics in handling clients' data.

## **Do no harm**

Since this study aims to explore the participants' experiences, some emotional questions have triggered emotional discomfort such as sadness and crying during the interview session. Creswell (2014), Vanclay, Baines and Taylor (2013) suggested that doing no harm during the data collection process which means no harm will come to participants as a result of their research participation. Participants must not be exposed to pain or danger in the course of research and must be of no adverse consequences to a person caused by their participation because participation in social research sometimes will cause a participant to reflect on personal issues which brings about emotional distress (Vanclay, Baines, & Taylor, 2013).

When this situation occurs, the researcher has obligations to ensure that the continuation of the research interaction until there is resolution of the emotional distress aroused (Vanclay, Baines, & Taylor, 2013) to ensure rigour of research. For example, the

interview sessions were stopped to determine if they require any assistance or explanations for questions they have been asked. The interview sessions were continued after reassuring the participants by informing consent because they have the right to withdraw from the interview if they feel uncomfortable in expressing their stories and to ensure no harm to them. The participants allowed the interview session to be continued after they felt better, and no participants withdrew from the study.

### **3.7 Insider Perspectives**

Emic and etic perspectives are important because the research process, the study findings, and arguments made by the researcher impacted by these perspectives on the implications of these findings (Naaeke et al., 2011). Etic perspectives are those taken by a researcher who has no connection to the community being studied, while emic perspectives are taken by a researcher who is a member (Naaeke et al., 2011) and shares an identity, language, and experiential base (Asselin, 2003 in Dwyer & Buckle, 2009) of the community being studied. The insider role allows researcher a more rapid acceptance by the participants and who are more open with researcher to generate more in-depth data (Dwyer & Buckle, 2009).

Most of the participants in this study are Chinese. Being an insider, the researcher and the participants shared Chinese background, and some similarities such as language, religion, and culture. For example, the researcher spoke Mandarin, Cantonese and sometimes English with the participants during the interview sessions because Chinese languages such as Mandarin and Cantonese were more commonly spoken by ethnic Chinese and easily understood by both the researcher and the participants. The English language was used throughout the study especially in data analysis and report writing. Moreover, the family structure that is practiced by most of the Chinese participants and the researcher are quite

similar. For example, most of the Malaysian Chinese household practiced a nuclear family structure where a married couple would live together with their children rather than an extended family structure (Malaysian Chinese Ethnography, 2011).

In the nuclear family structure, parents will take care of their children and the children will take care of each other when their parents are not around but bonding within other family members is still maintained (Leigh, 2006). The men have the dominant position in decision making in the family since it is a patriarchal society, while the ladies are usually in-charge of the household domestic duties and taking care of the family members (Malaysian Culture, 2018). When one or both parents have passed away, the eldest sibling (regardless of gender) will have the right in making decision in the household, but the oldest family member will often have to consult before making any major decision (Malaysian Culture, 2018).

The religions practiced by the Malaysian Chinese are Buddhist and Christianity. Most of the participants are Buddhist, but some of them changed their religious affiliation to Christianity due to personal reasons. The researcher is also a Buddhist, but not a strict follower of the religion because the researcher did not adhere strictly to the teachings of Buddha. Due to the strong influence of culture and belief systems in help seeking behaviour among the Malaysian Chinese, it is undeniable that the researcher and the participants seek help from the traditional healers for health problems. For instance, the researcher sought help from the temple god medium or the Chinese *Tangki* where modern medication was rejected when dealing with physical or mental health problems. Due to the similar practice of family structure, religious affiliation, and language shared by the researcher and the participants, rapport was built to ease the communication and interviewing process.

### **3.8 Validity and Reliability**

As a female researcher who is working with women, especially the Chinese women with mental health problems, some mixed feelings appeared during data collection process. For example, I was influenced by my emotions and feelings particularly when the participants shared their personal experiences on the admission process, interaction with children, as well as their adverse experiences faced at the centre. These feelings and emotions have affected me during data collection and data analysis. Since qualitative research seeks to understand individual construction (Peters, 2010) and thus subjectivity is a part of research process which might lead to systematic and random errors and consider to be harmful to the validity and reliability of research (Maso, 2003). Validity refers to the “truthfulness of findings”, while reliability refers to the “stability of findings” (Carpenter & Suto, 2008, p. 148).

In order to reduce researcher’s bias, and enhance the rigor and trustworthiness of the study, I have recognised the mutuality as part of the research (Oakley, 1990 in Johnson, 1998), the findings represent as closely as possible the participants’ experiences, as well as sending the transcripts and findings for back-translation by translator. Since this study is guided by feminist theoretical framework, reflexivity is an essential characteristic in qualitative research to help the researcher to be objectively distant from the research to reduce researcher’s bias (Liamputtong, 2009). To accomplish this, for example, I have written field notes and an article that related to my experiences, biases and feelings especially during interview session that helped me to be transparent throughout the data transcription, analysis and writing-up. It also helps me to be more open-minded throughout the research process by making the researcher’s personal and intellectual biases explicit (Mays & Pope, 2000).



### **3.9 Limitations**

One of the limitations is that the findings of this study might not be able to generalize to all people with mental health problems in Malaysia. This is because the selected participants and location in this study are chosen purposively thus not every individual with mental health problems who are staying at the mental health care settings had an equal opportunity to be chosen to participate by giving their response. For example, the study was conducted at West Malaysia specifically in Perak state where the centre was located which is one of the most established mental health referral centres in Malaysia that treats and cares for people with mental health problems and has only accommodated female residents who have been diagnosed with mental health problems and are currently being treated by a psychiatrist. Moreover, due to the selection criteria, those from different ethnic groups and those who are unable to communicate or suffering from acute conditions were excluded from this study that might lead to biases as not all residents in the centre included in the study.

Another limitation faced in this study is the loss of potential participants due to discharged, passed away, rejection and going home during festive season, thus they could not make it for this study. It is inappropriate for the researcher to go to their home to find them and force those who rejected to participate in the study due to research ethics since the study focused on the experiences of the women with mental health problems who are currently staying at the selected centre, as well as due to limited monetary resources and timeframe. Therefore, due to a small sample size, the findings are unlikely to fully generalize to the whole populations of people with mental health problems in Malaysia.

### **3.10 Conclusion**

In conclusion, this research is based on qualitative research approach. The research site and participants were purposively selected in relevance to the research title. The

participants' experiences were collected through a face-to-face and in-depth interview and analysed using thematic analysis. The insider view was discussed in the latter part of this chapter to provide some insights that could have affected the research. The research ethics have also emphasized to not harm the participants. Since a small sample size was used, generalisation is difficult to make.

## **CHAPTER 4**

### **FINDINGS AND DISCUSSION**

This chapter addressed the analysis of the findings for the two research questions by using the verbatim quotes of the participants that transcribed with the use of transcription key (refer to Appendix G) to indicate the tone and expressions shown by the participants (Padgett, 2017; Powick & Tilley, 2002; Speer, 2008). The first section presents the demography of the 12 participants to have a brief understanding on them. The second section explores the experiences of the participants before admission to the centre which answered the first research question on experiences that leading them to be admitted to the centre. The third section explores the experiences of the participants after admission to the centre which answered the second research question on the experiences in the care centre. The perspectives of the participants as a woman with mental health problems is also presented in this section.

#### **4.1 Description of Participants**

There were twelve participants interviewed in this study. All twelve participants are women diagnosed with mental health problems. Pseudonyms are used to replace the names of the participants throughout the report writing to guarantee the confidentiality of the participants.

##### **4.1.1 Age of Participants**

The participants in this study consists of one participant in the age range of 30, six participants at the age range of 40, three participants at the age range of 50, and two participants at the age range of 60. Majority of the participants in this study were mainly from the age range of 40, this showed that the people with mental health problems were

receiving rehabilitation at the care centre at the age range of 40 after receiving mental health treatment at general or mental hospitals. Moreover, this provided me an opportunity to approach the individuals with mental health problems as they are currently staying at the care centre. Therefore, this allowed me access to the participants easily especially through rapport building before during my internship at the centre.

**Table 4.1:** Age range of participants

Age range of participants	Number of participants
30-39	1
40-49	6
50-59	3
60-69	2
Total	12

(Source: Interview guide, Section 1)

#### **4.1.2 Marital Status of Participants**

The participants in this study consisted of ten participants who are single or never married and two participants who are married and have children. Majority of the participants are single or never married, this showed that the people with mental health problems especially women have never married and remained single when they are suffering mental health problems. However, some people with mental health problems were married before succumbing from mental health problems and have children with their partners. This might indicate that people with mental health problems might marry despite suffering mental health problems.

**Table 4.2:** Marital Status of Participants

Marital status of participants	Number of Participants
Single	10
Married	2
Total	12

(Source: Interview guide, Section 1)

#### **4.1.3 Education Level of Participants**

The participants in this study consisted of nine participants that graduated from secondary school with six of them finishing school at Form three, two of them finishing at Form 5, and one of them finishing at Form 1. While, one participant continued her study and graduated from polytechnic, and two participants graduated from university. This showed that the experiences of people with mental health problems might not be influenced by their educational background. There were more participants graduating from secondary school level compared to university level. This might indicate that people with mental health problems received education to secondary school level before or after suffering from mental health problems.

**Table 4.3:** Education level of participants

Education level of participants	Number of participants
Secondary School	9
Polytechnic	1
University	2
Total	12

(Source: Interview guide, Section 1)

#### 4.1.4 Religious Affiliation of Participants

The participants in this study consisted of four participants who are Buddhist, seven participants who are Christians, and one participant with no religious affiliation. This showed that the experiences of people with mental health problems might be influenced by their religious background. There were more participants affiliated with Christianity compared to Buddhism. This might indicate that the experiences of people with mental health problems might be influenced by their Christian background.

**Table 4.4:** Religion affiliation of participants

Religion affiliation of participants	Number of participants
Buddhism	4
Christianity	7
No religious affiliation	1
Total	12

(Source: Interview guide, Section 1)

#### 4.1.5 Origins of Participants

The participants in this study consisted of three participants who originate from Penang, seven participants who are from Perak, one participant who comes from Malacca, and one participant who is from Terengganu. This showed that the different regions might differently affect the experiences of people with mental health problems.

**Table 4.5:** Origins of participants

Origins of participants	Number of participants
Penang	3
Perak	7
Malacca	1
Terengganu	1
Total	12

(Source: Interview guide, Section 1)

#### **4.1.6 Year Range of Staying at the Centre of Participants**

The participants in this study consisted of ten participants who have stayed at the centre less than or equal to 10 years, and two participants who have stayed at the centre for more than 10 years, this showed that the people with mental health problems required more time in receiving rehabilitation at the care centre than receiving mental health treatment at general or mental hospitals. Moreover, this might indicate that people with mental health problems spend more time staying at the care centre as compared to general or mental hospitals. This also indicate that they have left their hometown and separated from their family for certain time.

**Table 4.6:** Years range of staying at the centre of participants

Year range of staying at the centre of participants	Number of participants
Less than or equal to 10 years	10
More than 10 years	2
Total	12

(Source: Interview guide, Section 1)

#### 4.1.7 Diagnosis of Participants

The participants in this study consisted of six participants who are diagnosed with schizophrenia, three participants diagnosed with depression, and three participants diagnosed with bipolar disorder. Only the women with these mental health problems were chosen in this study because women predominate in the prevalence rates in these mental health problems (WHO, 2018; National Institute of Mental Health, 2018). This indicate that only the experiences of people with schizophrenia, depression and bipolar disorder are explored in this study.

**Table 4.7:** Diagnosis of participants

Diagnosis of participants	Number of participants
Schizophrenia	6
Depression	3
Bipolar Disorder	3
Total	12

(Source: Interview guide, Section 1)

#### 4.1.8 Brief Summary of Participants' Stories

Table 4.8 presents a brief summary of the twelve participants' stories in terms of family background, occupation and experience before and after diagnosed with mental health problems.



**Table 4.8:** Brief summary of participants' stories

Participants	Brief summary of participants' stories
Koh	She has one younger sister who is working at Penang and her parents have passed away. She started to take medicine prescribed when she was first diagnosed with a mental issue since 1990 while studying overseas. She started to hear “voices” but the condition was not so severe. Her condition became serious in year 2005 when she thought about lots of thing, suffered insomnia, and constantly talking to herself at the time she was working with her father as an investor. She went to see doctor at a private hospital and took prescribed medicine every three months for approximately twenty years. She was also admitted to general hospital to receive treatment for six weeks before coming to the centre. She has received injection for about three years and reviewed regularly at Hospital Bahagia on second Wednesday of every month as her condition worsened. She believed that her mental health problem was caused by study pressure instead of religious belief because she is not so religious.
Cheng	She was 17 years old when diagnosed with mental health problem. She believed that it was caused by study pressure and the <i>feng shui</i> <sup>11</sup> of the house after moving to Perak as she played with the altar at home. She has received treatment at general and mental hospital before coming to the centre. She has also been readmitted and discharged multiple times from the hospitals. Before that, she has worked as a sale girl with eight years experiences at various supermarkets in Perak. Her mother who worked as a cleaner at the supermarket introduced her the job as a lady apparel promoter and a coffee shop waitress. Her condition become worse after she stopped working and after her father passed away.

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<sup>11</sup> *Feng Shui* is a traditional cultural practice based on the dynamics of qi energy in the human and natural environment of the world that affected the development of landscapes. *Feng* is the Chinese term for wind, and *Shui* is the term for water (Mills, 1999).

**Table 4.8** continued

Hong	She is married and has a son who is now 30 years old and a daughter who is 25 years old. Both of her children are working. She is a housewife and does some house work such as folding worship paper introduced by her sister. She has three sisters and some friends but seldom contacted and thus just socializes with her children and neighbour. Sometimes, she will teach her neighbours to fold the worship paper. She has good relationship with her sisters, but sometimes will be reprimanded by one of them who also forbid her to mix with her daughter in law and grandson.
Sim	She is married and has two daughters who are 13 and 14 years old. She has worked as a teacher at a kindergarten and primary school at Johor that was introduced by her sister. She stopped working when there was an outburst and after that applied to go back and worked at her hometown. She was recruited by the centre supervisor as a staff to do some paper work after rehabilitation. However, she was paid poorly for working long hours and thus refused to work at the centre and then worked as a chef. Since she is good in dancing, she is now recruited again as a rehabilitation staff to help the other residents' rehabilitation. She misses her children dearly because she was separated from them when staying and working at the centre.
Tan	She believed that her mental health problem was caused by study pressure. She is the only child in her family. She feels lonely when her parents were not around, causing her to overthink. Before her mother passed away, she was living with her parents who loved her and took care of her. She never did housework at home since her parents had hired a maid. Her condition worsened after her mother passed away and her father remarried. She was alienated and sent to the centre since her father has a new family, but her father and her step mother would come to visit her once in every two months. She discovered that her step mother and half siblings have not much talk to her maybe they do not like her since she is a person with mental disabilities. She also does not like them when her mother was alive to protect her mother, but now is able forgive them after her mother had passed away and said that it is a fact that cannot change. She is afraid that her father will leave her alone at the centre if she continues to hold grudges against him. She followed the Bible teaching to forgive people, the past is the past and she does not care about it.

**Table 4.8** continued

Sandy	<p>She started to take medication once diagnosed with mental issues at 26 years old. She was offered a job and moved to Perak upon graduation. Before moving to Perak, she and her family were staying at Malacca in her relative's house. Her relative disliked and cursed them because they were financially dependent on them. Once her father passed away and graduated, she got a job and left the house, while her brother continued his education at university. She worked as a government servant at the Geological Survey Department in Perak and promoted to work at the museum which is located in the same building before retiring. She got sick because her boyfriend scammed her of her savings. She was then cheated again by another boyfriend who is also her colleague and transferred to another state to work. She felt heartbroken when she knew that her second boyfriend married with another woman which caused her condition to worsen. She continued to take medicine and treatment when she was working, but she relapses again at 55 years old. Before coming to the centre, she was staying at a nursing home, but she was unsatisfied with the services provided by the home. She then come to this centre which is specially for people with mental health problems. She was reluctant to come at first but found that her brother has lot of difficulties and thus decided to stay at the centre.</p>
Chai	<p>She was diagnosed with mental health problem as she hears "voices" trying to kill her when she was 18 years old because she has made two pen pals. She started to take medication at 18 years old but not institutionalized since she was young. She has nine siblings and she is the fifth child. She has four older brothers, two younger sisters, and two younger brothers. She was not working before since she was sick. She stayed with her parents and took care of her sick mother. Her condition worsened after her mother has passed away. She also received electric compulsion treatment during her stay at mental hospital for about two years.</p>

**Table 4.8** continued

Hoon	<p>She graduated from UPM Terengganu, majoring in counselling and minoring in business. Once graduated, she worked as a secondary school teacher in Miri, Sarawak for about four years but was rejected when applied to transfer back to West Malaysia and then she started to get sick. Her mental health problem is caused by work stress. She is an introvert who seldom shares her problems to others and stayed alone when working at Sarawak. She went back home after getting sick and was looked after by her younger sisters. She has five siblings and she is the eldest, with three younger sisters and a younger brother. Her younger sisters worked as teachers and clerk, while younger brother is a doctor working at Singapore. Before coming to the centre, she was staying with her mother who is alive and is now 64 years old.</p>
Lai	<p>She was sick because of working stress, love, family and friends. Her father had passed away and her mother is now staying at Ipoh. She has one younger brother who is staying at Kuala Lumpur. She is the eldest child. She worked as a shampoo girl before at Penang and Malacca. Her mother will come to centre to visit her when she is free. She will have a short stay at home during Chinese New Year. She is now working part time at the centre to earn some money. She helps to prepare vegetables in the kitchen and clean the centre office. Sometimes, she helps to wash the plate after any parties. She also does candle treading when free to pass her time at the centre.</p>
Woon	<p>She has seven siblings and she is the fifth child. Her two younger sisters worked as air hostess and her older sisters are working at Genting Highland. Some of her sisters have married and stay in different states. She has never worked before getting sick and stayed together with her mother. She was admitted to the centre because of domestic abuse against her mother. She could not remember the exact reason for beating her mother. She has a good relationship with her siblings, and they will visit her once every two to three weeks to bring her out for food and shopping. She is doing occupational therapy such as plastic bags threading to earn some money.</p>

**Table 4.8** continued

Ee	She always washed her feet and felt that it was smelly when diagnosed with mental health problem. She has one older brother and her parents have passed away. She worked as a sales girl and waitress before getting sick but has stop working after getting sick. She stayed alone at the house left by her parents before coming to the centre, while her brother was working and staying at Kuala Lumpur. She is doing occupational therapy such as candle threading to pass time and earn some money at the centre. She is not interested in watching television and other rehabilitation activities. She also does some small tasks such as mopping the floor, washing plates, and cleaning windows when staying at the centre.
Boon	She was diagnosed with mental health problem because of study pressure. She has three siblings and she is the eldest. She has one younger brother and one younger sister. Her younger brother owns a business, while her younger sister worked as a clerk at Kuala Lumpur. She never worked before and did some housework at home because she will relapse once in a week. She has to take medicine and review once in a month, but she refused to take the medicine and throws it away. She has been admitted to the Terengganu General Hospital by the police because she ran away from home. She has been admitted four times to the hospitals to receive treatment such as one and a half year for the first and third time, and half a year for the second and fourth time. She likes to join rehabilitation activities such as exercising, singing, and dancing. Sometimes, she helps to clean the workshop and works at the orchid farm.

(Source: Interview guide, Section 2)

## **4.2 Experiences Before Admission**

The experiences of participants that leading them to be admitted to the centre were explored through the question “Would you like to share with about your experiences of admission to the centre?”. The experiences of participants before becoming sick also explored in this section through the question “Would you like to share with me about your experience before becoming sick?”. The finding for the experiences before admission is explored through the understanding, narration and interpretation by the women with mental health problems. After analysed the transcripts, the experiences of participants had explored

such as their age onset of mental health problems, informal help-seeking behaviour, admission to inpatient care and care centre, and relationship with family. Table 4.9 shows the first theme that emerged from the subthemes.

**Table 4.9:** Experiences Before Admission

<b>Theme 1: Experiences Before Admission</b>
Subtheme 1: Age Onset of Mental Health Problems
Subtheme 2: Help-seeking Behaviour
Subtheme 3: Admission to the Inpatient Care
Subtheme 4: Admission to the Care Centre
<ul style="list-style-type: none"> <li>• Reasons of Admission</li> <li>• Decision Making on Admission</li> </ul>

#### **4.2.1 Age Onset of Mental Health Problems**

From the finding, the age onset of mental health problems of the participants begins during their teenage years and adulthood depending on their mental health problems. The participants with schizophrenia and bipolar disorder begin during their teen years especially during studying, while participants with depression started during their adulthood. One of the participants with depression experienced relapse in her adulthood. The participants described that:

“Oh. [It happened when I was] **studying**. When I nearly finished my university course, I got sick.” (Koh, Schizophrenia)

“After [**studying**] for two years then I got sick. [I get] mental illness.” (Sim, Bipolar Disorder)

“Before I get sick, [I] get mental illness, I get sick at **26 years old** and taking medication. Then it becomes more serious when [I’m] almost **55 years old.**” (Sandy, Depression)

The finding indicated that the symptoms that presented by the participants are different based on their mental health problems such as those experienced schizophrenia was hearing voices like people trying to kill her; those with depression suffered from delusions, loneliness and long-term depression; and those with bipolar disorder experienced hot temper and a troubled feeling. The participants disclosed that

“I **hear voices**, voices, like **somebody wants to kill me.**” (Chai, Schizophrenia)

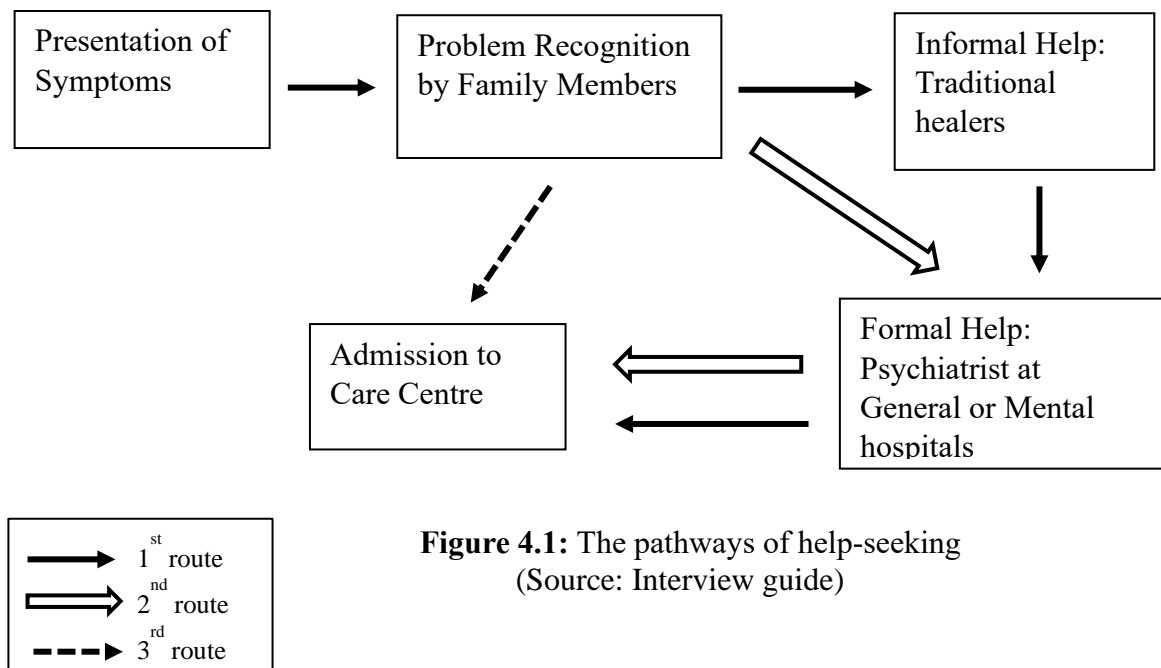
“[I’m] easily **angered.** When I was sick, I will break things to release my anger.” (Lai, Bipolar Disorder)

“I always have **delusions.** I began feeling **lonely**, [felt that I was] alone.” (Tan, Depression)

The finding also showed that the participants experienced suicide and have suicidal thoughts that caused by the hardship of mental health problems. The participants have been diagnosed with schizophrenia, depression, and bipolar disorder by the psychiatrists based on the medically accepted classification systems - International Classification of Diseases (ICD) that was developed by the WHO and the American Psychiatric Association’s DSM. The finding showed that the age onset and the symptoms that were presented by the participants are concurrent with the classification systems (refer to Table 2.1, p. 16). Due to the presented symptoms, the participants were diagnosed by medical professionals to having mental health problems.

## 4.2.2 Help-Seeking Behaviour

The finding indicated a pathway of help seeking of the participants was identified and illustrated in Figure 4.1. Each of the routes was discussed separately in the Subsection 4.2.2, Subsection 4.2.3, and Subsection 4.2.4 to have an understanding on the experiences of the participants that leading them to be admitted to the centre.



Family members such as parents, siblings, and children usually are the first person who recognized the problems that faced by the participants. When help outside the family was needed, it would usually come in the form of informal help such as traditional treatment from traditional healers before deciding to go for formal help (first route) after presented symptoms of mental health problems. This is because cultural believes (refer to pp. 18-22) that practiced by an individual will affect their help-seeking behaviour and illness labelling without regarding their educational level. For example, in Chinese culture, people with mental health problems believed to be possessed by “spirits”. In order to exorcise the evil



spirits, shamanistic healing has been used to invoke supernatural powers in healing (Ling, 2007). From the finding, this type of traditional treatment is sought by most of the participants by their family members who were among the first people to recognise their problems and believed that they were bewitched. The participants mentioned that

“When [I] becoming sick, my mother thought that... thought that I was **bewitched**. She went to the **Indian temple, and Chinese temple**, to **search for the spells** to treat me, and [it] can’t treat [me] well, but [the condition] got worst.” (Tan, 42)

“Last time my family member always brings me to ask the **god medium**. [Give me] drink that water “符水”, see the palm, [and] also asked that puppet, writing, cards in ABC. [They] go to ask that god medium, go anywhere to ask.” (Lai, 38)

Based on the Chinese cultural believed system, the shaman or the Chinese *tangki* (a medium as referred in English) are believed to be able to enter a trance state to communicate with the guiding spirits to exorcise evil spirits and to usher back the lost soul of the inflicted person (Ling, 2007). The shamanistic healers will perform something tangible such as providing a “*fu*” (a protective charm), giving a *mantra* (spell) or performing a ritual in providing treatment because they are believed to be the “experts” in diagnosing and identifying the source of the problem and offer appropriate intervention (Ling, 2007).

However, this traditional treatment has no effect and often cannot cure the participant’s mental health problems but worsen their condition. As explained by the participants

“My condition became **worst**.” “No, [it] totally didn’t help. **No! No!**” (Tan, 42)

“I feel like [I was] semi-conscious after drinking it. [It’s] Like...psychic like this.” (Cheng, 42)

From the participants’ narratives, the informal help would be sought first before formal help which is heavily influenced by their cultural belief system in help-seeking process. The participants’ family members were among the first people who recognised their problems and seek traditional help for them as mentioned by the participants. Moreover, the participants would also choose to talk or discuss their problems with their family members or friends.

#### **4.2.3 Admission to Inpatient Care**

The formal help from a psychiatrist or medical professional would be a second choice if the traditional treatment was deemed ineffective or when problems become serious. This finding is in line with the argument by Lim (2015) that professional help such as psychiatrist or others health facilities is always the last choice for the people who suffered from mental health problems. However, the finding showed that some people with mental health problems would straight away approach the formal health care settings after their symptoms presented and recognised by themselves or family members as showed in the second route. Sometimes, people with mental health problems would be admitted by the police officer to the formal health care settings when reported by their family members who recognised their problems.

The participants have experienced admission to the inpatient care at general hospital or mental hospital for a certain period to receive treatment after their mental health problems were diagnosed by a psychiatrist or medical professional and the traditional treatment by traditional healers was ineffective. The participants have experienced a short-stays (e.g. two

to six weeks) at general hospital and a long-stays (e.g. two years) at mental hospital once diagnosed by the psychiatrist or medical professional. As recalled by the participants

“I have stayed at the **Hospital Terengganu** for four times. The first time is about **one and a half year**, the second time is about half a year, the third time is about one and a half year, and the fourth time is about half year.”  
(Boon, 63)

“[I have been] **Admitted into ward**. At ward 24 first, then I go back to home, and admitted [again] to **Tanjong Rambutan**.” (Cheng, 42)

“Seem like they call the **police** and ask the police to catch me to stay at **hospital**. Is my family member [who call the police].” (Sim, 44)

One participant recalled and mentioned that she went to see a doctor at formal health care settings and took the prescribed medication, but she was not been admitted and stayed at there. The participant mentioned that

“My mother brought me to **Tanjong Rambutan**<sup>12</sup> that year, and the **doctor** gave me medication that time. The doctor has said that won’t admit me to the hospital and asked my mother to bring me back. Then my mother brought me back home and went to **Hospital Lumut** to take medicine.”  
(Chai, 57)

The participants admitted to general hospital with longest period for about one year and about two years at mental hospital. Moreover, the participants were not only admitted to general hospital, but also would be admitted to mental hospitals to receive treatment after they were diagnosed with mental health problems. The participants went to the general hospitals to consult a doctor or review and took prescribed medicine. Normally, the

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<sup>12</sup> Hospital Bahagia Ulu Kinta also known as HBUK in short form or Tanjong Rambutan since it was in Tanjong Rambutan, a suburb of Ipoh, by the participants.

participants would be admitted again to the nearby mental or general hospitals to receive treatment if they experienced relapse.

Since people with mental health problems prefer to seek traditional help first and professional help last, Razali (1995) has suggested in his study that there is a need for cooperation between the traditional healers and the medical professionals by having a discussion to promote mutual referral. This is because there are limitations in certain areas of their services such as recognition of psychotic illnesses by the traditional healers and lack of knowledge in the services users' cultural and religious beliefs by the medical professional (Razali, 1995). Hence, through cooperation, the understanding of medical professional and traditional can be improved and will be beneficial for the people with mental health problems, as well as helped their family members in making help-seeking decision (Razali, 1995).

#### **4.2.4 Admission to the Care Centre**

Admission to the care centre by the family members as showed in the first and second route would be the last choice especially after discharged from the previous inpatient health care settings – general hospital or mental hospital. Some people with mental health problems would straight away send to care centre by their family members once recognised their problems (third route). From the finding, the participants were sent and admitted to the care centre by their family members either voluntary or involuntary based on several reasons and decision make as discussed below.

##### **Reasons of Admission**

From the participants' narratives, the reasons of the participants being admitted to the care centre include for rehabilitation, no caretaker, insufficient amount of beds at hospital, and “violent” behaviors such as beating and “disobedience”. The participants explained that

“Doctor talked to my family member like this [admit to the centre]. Their arrangement is like this [admit to the centre] because he said to have **rehabilitation** here is [such as] to do activity. He wants me to fully recover.” (Sim, 44)

“Because I’m always in and out from the hospital, so the doctor recommends [the centre] for me. [He] said that there was one centre here, so [I] no need to [always] in and out from the hospital, and hospital [also] **does not has empty place** for me to long stay. So, I come to this centre.” (Hoon, 42)

“I like to beat my mother. [Because I] was **beating** my mother, so they sent me here.” (Woon, 57)

However, one participant said that she felt pity and hard to her brother if she rejected to stay at the centre since her brother has to take care of his family and her at the same time.

“Because that time he also has many worries. His first daughter was working at England, [and he] also need to take care of me. It’s hard for him to run around. I see him so pity [when I’m] at hospital, so I decide to settle down at here.” (Sandy, 63)

Moreover, some participants were admitted to the centre because there is no one to take care of them at home and thus they are left alone. This is because the participants normally stayed with their parents at home and were taken care by them. When their parents passed away or grew old, the carer role was taken over by others such as siblings, children, or relatives. However, the other family members might have their own family to take care of or are busy working, thus they have no choice and decided to send the participants to the centre. Therefore, due to the reasons mentioned by the participants, they have been admitted to the centre. The participants were found spent most of their time staying at the care centre as compared to other health care settings. For example, one participant has stayed more than

thirty years at the centre who was admitted at 26 years old, while the other participants were admitted as recent as November 2015.

### **Decision Making on Admission**

From the finding, men in the family such as father and brother have made the decision on the participants' health care services since all the participants in this study are Chinese women who have less involvement in decision making process on receiving their health care services especially their admission to the care centre. Apart from the reasons such as for rehabilitation, no caretaker, and not enough beds in hospitals, lack of involvement in decision making is another important reason that leading them to be admitted to the care centre. This is because most of the participants mentioned that admission to the centre is not their decision, but the decision made by their family members such as father and brother. Hence, this subtheme has emphasized the participant's experiences in decision making on admission to the centre and discussed in a separate section. The participants claimed that they have no chance to take part in the decision-making process such as:

“[Admission to centre] is my **father's decision**. [It's] **Not my decision**. I don't like here. I have told him about that. But he still let me to stay here. I have no idea. It's not my choice to stay here.” (Tan, 42)

“No! It is my **brother and his wife's decision**. I don't know [the admission] at first, [I] just follow their opinion.” (Sandy, 63)

“No! No! [It's] **not my decision**. [It's] my **sister decision**. Because my sister [felt] too busy to take care of me.” (Koh, 48)

The finding showed that the participants have lack involvement in decision making on the admission to the centre which is differing from the findings of Ambigapathy, Chia, and Ng (2016), Cost et al. (2017), and Dahlqvist\_Jonsson et al. (2015) who found that health

care service users preferred shared and active participating in decision making to receive health care services. The finding also found that the participants' family members made the decision on their admission was mainly made upon the recommendation of the doctor. The participants mentioned that their family members knew about this centre from the doctor's recommendation. The participants' family members then decided to send them to the centre due to the reasons mentioned above such as for rehabilitation and nobody to take care of them at home. As stated by the participants

“[When I was] admit into ward, the **doctor recommended** me to come here.” “[It's] of course my sister's decision. She knew about this centre at ward 24, [then] she asked my younger brother to send me here.” (Cheng, 42)

“I was admitted to the hospital there, then [the doctor] recommend coming here. [It's] not my choice. The hospital gave the name card. They **recommend** to my family member. Then my sister-in-law also searched from internet. Just like this.” (Sim, 44)

The findings showed that family members such as parents or siblings who is the eldest among the siblings either brother or sister are the people responsible for making the decision on the participants' admission to the centre under the recommendation of the doctor from general or mental hospitals, but the participants are not involved in the decision-making process. The participants have no choice and thus comply with their family's decision to show respect for the elders or out of filial piety. Therefore, either the journey to the centre is voluntary or involuntary, the participants end up getting admitted into the centre.

Goffman (1961 in Cockerham, 2000) explained that the treatment seeking process involved different agents and agencies such as the next-of-kin, the complainant, and the mediators, and thus an individual's treatment seeking process were divided into coerced and

unforced situations. From the finding, the participants' admission to the centre is understood as a coerced situation since it is an involuntary commitment between their family members and the psychiatrist upon the participants although it was based on the best interest of the participants according to the professionals' superior training and knowledge, as well as the authorization if the next-of-kin (Cockerham, 2000). Moreover, the centre admission has been classified as voluntary in the Malaysia Mental Health Act 2001 under section 31 (1)<sup>13</sup>.

Feminist perspectives perceived decision making on women's health care in a different way which believed that oppression penetrates in decision-making as a constant phenomenon and thus proposed equal rights, equal treatment, and caring as the basic values in nursing feminist theorist (Wittmann-Price, 2004). Moreover, feminist model practice on women's health care aims to change women's health care delivery and seek transformation through shared decision-making to empower the women and enhance their knowledge on health care (Andrist, 1997). Therefore, feminist approach can be an important step in empowering women by making their own choices and rejecting the male definition of femininity and women's sexuality as a major factor in choosing treatment (Szumacher, 2006).

However, Chinese men in Malaysia continue to occupy the dominant position in the family particularly in decision making (Leigh, 2006; Noor, 1999) since most of the Chinese households are made up of nuclear families (Yusof, 2015) that consist of husband and wife living with their children (Leigh, 2006). Yusof (2015) in his study showed that Chinese households in Malaysia were more traditional and patriarchal where the husband dominates

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<sup>13</sup> Section 31 (1) Subject to subsections (2) and (3), a person who is suffering or convalescing from mental disorder may be admitted into a psychiatric nursing home as a voluntary patient – (a) upon his own request, (b) upon the request of a relative, or (c) upon the request of a Medical Director of a psychiatric hospital. (2) Notwithstanding subsection (1), no person shall be admitted into a psychiatric nursing home except under the direction of a medical officer or registered medical practitioner who is preferably a psychiatrist. (3) The patient referred to in subsection (1) shall not be admitted into the psychiatric nursing home except for the purpose of providing him with accommodation and nursing and rehabilitation care (Mental Health Act 2001, 2006).



in the decision on household financial matters. Women in the family must abide by the traditional cultural and religious values and thus must conform the man's decisions (Noor, 1999).

Based on the feminist perspectives and traditional practices, women were not only oppressed by the "patriarchy" in the family structure, but also in the social and political structure on health care since feminists believed that society was constructed by males which was directed by men for the benefit of men (Jebali, 1995) and also claimed that the state's interests put first before those for women in male-dominated government policies (Lorber, 1997), thus agreeing that existing sexist oppression is wrong and must be abolished (Szumacher, 2006). Hence, the gazetted mental health act and policies by the Malaysian government that guided the mental health services to ensure justice and equal rights of the society were found oppressing women with mental health problems since it has violated the women's right in receiving health care services.

Moreover, the finding found that the participants did not know or ever mention about the mental health act although it existed shows that little exposure of the relevant law to the related people, and thus there is a need to improve the awareness of the law to the public. Moreover, the finding also found that none of the participants sought help from a social worker in the identified help-seeking pathway (refer Figure 4.1, p.90) although social workers exist in the helping system and was mentioned in the Malaysia Mental Health Act 2001 (2006) as social welfare officer<sup>14</sup>. This finding is corresponding with the study

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<sup>14</sup> Social welfare officer in the Malaysia Mental Health Act 2001 (2006) means any social welfare officer in the Ministry of Health, Malaysia or in the Ministry or Department responsible for welfare services. Social welfare officer as mentioned in the Act under section 11 for the apprehension of person with mental health problem. As in Section 11 (1), any police officer or social welfare officer may apprehend any person whom has reason to believe is mentally disordered and is, because of mental disorder, dangerous to himself or to other persons or property. (2) The police officer or social welfare officer who has apprehended a person under subsection (1) shall as soon as practicable, but not later than twenty-four hours after the apprehension, bring the person to a registered medical practitioner in a gazetted private psychiatric hospital for examination (Mental Health Act 2001, 2006).

conducted by Yusof, Ramli, and Noor (2017) who stated that the Malaysian psychiatric or assigned mental health social workers have yet to be recognised for its importance because have less understanding or not realising their roles in providing mental health support and lacking of referrals although the mental health treatment are more community-based than medical in the policy.

As compared to the psychiatric social workers in the United States, they have varied responsibilities according to their work setting (SocialWorkLicensure.org, 2018). For example, they conduct psychosocial assessments, provide psychotherapy and other clinical services, communicate and coordinate with the treatment team, connect clients with relevant resources and services, as well as facilitate clients' discharge plan and follow-ups in inpatient settings (Louie, 2018). While, those in outpatient settings perform psychotherapies and assessments, educate patients and their families, as well as make referrals if necessary (SocialWorkLicensure.org, 2018). Therefore, Ling (2007) has suggested that the Malaysian social workers should develop an alternative to improve, strengthen and support the existing helping systems. Moreover, it is hoped that the finding could help the Malaysian psychiatrist or mental health social workers by improving their knowledge on the client's help-seeking behaviour with different cultural backgrounds since Malaysia is a multi-cultural country and help to have a better understanding in having a clear role to engage in the helping systems as a choice for the help-seekers.

#### **4.3 Living Experiences in the Centre**

This section focuses on the experiences of the participants in the care centre. This section also emphasizes the participants' thoughts on being a person with mental health problems which act as a platform for them to voice out their point of views. Due to the difficulty in understanding the question "How do you perceived yourselves as a woman with

mental health problem?”, to continue to explore the participants’ perceptions this question has changed to explore their perception on discrimination experiences and women position in family, and thus more ideas emerged. The experiences and thoughts are understood and interpreted through in-depth interviewing with the participants and discussed in seven subsections such as the relationship with family members, centre staffs, and other residents, being “oppressed” by the centre staffs and medical practitioner, isolation and separation with family members, change of religious affiliation, satisfaction of staying at the centre, preference of living at home, and self-perception. Table 4.10 shows the emerged subthemes in the second themes.

**Table 4.10: Living Experiences in the Centre**

<b>Theme 2: Living Experiences in the Centre</b>
Subtheme 1: Relationship <ul style="list-style-type: none"> <li>• Family Members</li> <li>• Other Residents</li> <li>• Centre Staffs</li> </ul>
Subtheme 2: “Oppressed” by Centre Staffs and Medical Practitioner
Subtheme 3: Isolation and Separation
Subtheme 4: From Buddhism to Christianity
Subtheme 5: Satisfaction of Staying at the Centre
Subtheme 6: Preference of Living at Home
Subtheme 7: Self-Perception <ul style="list-style-type: none"> <li>• As a Person with Mental Health Problem</li> <li>• Discrimination Experiences</li> <li>• Women Position in the Family</li> </ul>

#### 4.3.1 Relationship

A good relationship with the people surrounding is important for the residents in the care centre because it is a form of social support that is needed in their recovery process (Low, Lee & Jacob, 2017). The finding showed that a good relationship was formed between the participants with the people (e.g., family member, residents, and staffs at the centre) around them when they are staying at the centre and discussed below.

##### **Relationship with Family Members**

Family relationships in the form of social support (e.g., providing love, advice, and care) and stressor (e.g., argument, being critical, making too many demands) played a role for an individual's well-being through psychosocial, behavioural, and physiological pathways (Thomas, Liu, & Umberson, 2017). Stressors were argued might undermine mental health and well-being, while social support may serve as a protective resource (Pearlin, 1999). According to Symister and Friend (2003), family support might promote well-being of an individual through increased self-esteem in the form of psychological resource, encouraging optimism, positive affect, and better mental health.

Before admission to the centre, the finding showed that some participants have a good relationship with their family members, while some participants have a bad relationship with their family members. The finding also indicated that the numbers of participants who have a good relationship with family member have increased from six participants to eight participants when staying at the centre. The participants' understood that a good relationship with family members if there is no quarrelling, visited by family, and able to go out and shopping with their family members. The participants described that

“[Our relationship] is very **good**. [We] **never fight or quarrel**.” (Boon, 63)

The participant further explained that

“[It’s] Very good. Relationship [with my family] very good. They came to visit me. My younger sister and her husband always come to see me.”  
(Boon, 63)

The participant also has a good relationship with her family members even before admitted to the centre

“(Interrupted) My younger brother, his wife, and younger sister **never quarrel** [with me] la... [Our relationship is] **very good** la... (Boon, 63)

Another participant who has a good relationship with her family and explained that

“[Our relationship] is very **good**. We get along well.” (Woon, 57)

The participant continues to say that

“[They] have **come to see** me for a while. [They] just bring me **out to eat** yesterday. [They] **care** about me. [They] bring me out to eat, shopping, everything, and cutting hair (Laugh). [They] come to see me once every two to three weeks and bring me out. [It is] very **good**. All of them come to see me.” (Woon, 57)

The participant also has a good relationship with her family before admitted to the centre and described that

“[Relationship with family] **Very good** ah... [It’s] very good. [I] Have a good contact with them lo... Ah, [our relationship] before also very good.”  
(Woon, 57)

The finding showed that the relationship of some participants with their family members have underwent some changes such as improving from bad to good and vice versa. The

participant whose relationship with her family members has changed from good to become bad after admitted to the centre and stated that

“I seldom talk to him [her father]. Because I will call [him] when there is a need, if not I won’t call. I don’t want [to call him], as far as possible [I] don’t call. Because my father also... [Our] relationship also **not so good**.”  
(Tan, 42)

Before admitted to the centre, the participant has a good relationship with her father and said that

“My father and mother live together [with me]. My Father very **cared** about me that time.” (Tan, 42)

While, another participant whose relationship with family member has changed from bad to become better and claimed that

“[It became] much **better**. Because I understand Jesus... [I] experienced this problem [also is] Jesus help me.” (Sandy, 63)

Before admitted to the centre, the participant has a bad relationship with her family and explained that

“[It’s] **not so good**. [Because] I like to make the decisions alone. My brother doesn’t like me making decisions alone, [and I] **need to listen** to him.” (Sandy, 63)

In understanding the meaning of a good relationship with family members, the participants explained that they never quarrelled nor fight but are cared by their family members before coming to the centre. When the participants were constrained by their family members such as disallowing them to make decision on their own, and the feeling of rejection, they claimed that they have a bad relationship with their family members. The

finding showed that there was an increased number of participants (from 6 to 8) who have a good relationship with their family members although they have been separated with their family member for a long time especially for those who come from different states. The finding also showed that the participants felt happy that their family members were able to take time to come to the centre to visit them and bring them out from the centre for shopping and eating. Thomas, Liu, and Umberson (2017) point out that a positive family relationship can help an individual cope with stress, engage in healthier behaviours, and improve self-esteem to have better well-being, while a negative family relationship can affect an individual's well-being.

### **Relationship with Residents**

Social support and social relationships are essential to the residents' quality of life in the health care facilities to have a life in the facilities (Robert & Bowers, 2015). Having a life is a two-way process involved higher level of life motivations (e.g., being self and creating a positive atmosphere) and required daily activities (e.g., passing time) which have influenced the development and definition of relationship (Robert & Bowers, 2015). The finding indicated that the participants formed a new and good relationship with other residents when residing at the centre. From the understanding of the participants, the meaning of "good relationship" with the residents in the centre as treating them well, talking to them, and willing to make friends with them. As mentioned by the participants,

"I see them all are good. I'm **good with everyone**. Just that I don't know they treat me good or not. [I] don't know [how is] their heart, [whether] they don't like me [or not], I don't know." (Chai, 57)

"All **good**. [I] try my best to make friends with them [and] they are **willing to be my friend**." (Hong, 56)

“**Okay**. They **talk** to me when they want me to do something. I [then] do for them.” (Koh, 48)

However, there are participants would choose to mix with the residents who affiliated with the same religion, normal, and talked nicely with them because they share the same cultural background which help them feel supported and protect them from being hurt by the chronic residents for rehabilitation when living at the centre. This newly formed relationship also helps the participants to feel safe during their stay at the centre. As explained by the participants

“I quite **like** [to mix with] the **Christian residents**. I feel that they have more [in] the teaching of life. [I will] mix with them automatically. Others [I] don’t dare to mix. [I’m] **Afraid**.” (Tan, 42)

“I will approach those who **talk nicely**.” (Sandy, 63)

Therefore, the finding found that the participants have a good relationship with other residents in the centre based on their interaction with other residents. To motivate the interaction, the participants have been friendly and avoided conflict and distressing situation (Robert & Bowers, 2015) among each other. The finding showed that some participants choose to be in a relationship with the residents who they like and avoid those with chronic condition due to afraid of getting hurt through beating and biting but showed a good relationship with other residents. Being self in the development of relationship with other residents motivated the participants to make decision based on their preferences and past experiences had influenced the type of relationship that developed with other residents (Robert & Bowers, 2015).



## Relationship with Staffs at the Centre

Therapeutic relationship is also important in the care of people with mental health problems which developed from the trust and respect between the caregivers and the service users to empower the service users in receiving health care (Kuluski et al., 2017; Laugharne et al., 2012; Penda, 2017). The finding showed that the participants have formed a good relationship with the staffs at the centre. Based on the understanding of the participants, they have good relationship with the staffs when they were not being scolded by the staffs, followed the staffs' instruction, and well treated by not admitting them to the mental hospital. As described by the participants

“[Our relationship is] **Good**.” Then the participant further explained that “The staff **didn’t scold** me.” (Cheng, 42)

“[Relationship with] staff also same. [It’s] same as last time.” Then the participant further explained that “They **didn’t admit** me. If [I] do bad thing or what, they will admit me [to mental hospital]. This [no admission] means they **treat me good**.” (Chai, 57)

“[It’s] **okay**.” Then the participant further explained that “Maybe the staffs ask us to do [something], we just do and **follow their instruction**.” (Koh, 48)

However, there are participants have a bad relationship with the staffs at the centre when the staffs scolded them and talked to them impolitely. As explained by the participants

“[Our relationship] **not very good**. They **don’t know [how] to talk well**. They want to **scold** people from day to night. So, [I] don’t like.” (Sandy, 63)

“I have nothing much to talk to the staffs. I feel like they **oppress** people.” (Tan, 42)

The finding found that the participants showed a good relationship with the staffs by explaining that they were not scolded by the staffs and followed the staffs' instruction. If the participants disobeyed the staffs' instruction or quarrelled with the staffs and residents, they would be "threatened" to be admitted to the mental hospital. The participants are afraid of being admitted to the hospital because they feared the side effect caused by injections and medication. Moreover, for those who have been scolded or dislike the staffs' talking way, the participants were found have a bad relationship with the staffs and led them unwilling to talk to the staffs. Penda (2017) in her study has argued that trust and communication are significant aspects of the therapeutic relationship that are reciprocally related as trust enables effective communication and vice versa which tend to mediate the therapeutic processes and indirectly affect the service users' health outcomes based on their willingness to engage or accept the services (Kuluski et al., 2017).

Therefore, a positive family relationship helps the participants to cope with stress, engage in healthier behaviours, and improve self-esteem to have better well-being (Thomas, Liu, & Umberson, 2017), social relationship with other residents helps the participants to have a life in the facilities (Robert & Bowers, 2015), and therapeutic relationship which developed from the trust and respect between the caregivers and the service users help to empower the participants in receiving health care (Kuluski et al., 2017; Laugharne et al., 2012; Penda, 2017). Hence, a good relationship with the people surrounding is important for the participants to improve their well-being.

#### **4.3.2 "Oppressed" by the Centre Staffs and Medical Practitioners**

Feminism concerned about the elimination of oppression (Gary, Sigsby, & Campbell, 1998) and thus emphasized the power relations between practitioners and patients in health care system (Avgar, 1997). This is because unequal interaction between doctor and patients

exist in health care system where the patients is in an inferior position who dependent on the doctors' knowledge, skills, and information has thus placed them in a relatively less powerful position (Avgar, 1997). Moreover, feminist theorists also proposed that women are able to learn who they are and what is important through relationship with others because they can experience mutual engagement, empathy and empowerment to improve their psychological well-being and physical health since relationships are also central to women's psychology development and integration, to women's empowerment, and to women's social roles (Lauver, 2000).

Although the participants formed a good relationship with the residents and the staffs at the centre, the finding indicated that living at the centre are negative experiences to the participants as the participants revealed that they experienced "oppression" by the staffs and the medical practitioners. The finding showed that the participants were being scolded by the staffs or ignored by the medical professionals when expressing their side effect caused by the medication such as eyes looking upward, feeling sleepy, and losing concentration. As described by the participants

"I have problem in taking medicines because it made me have **side effect** like my **eyes will always look upward**, made me very **sleepy**, and **lack of concentration**. My medicine also made me [feel] like always want to eat and **easy to feel hungry**. When taking medicine in the morning, I feel that my stomach starts to have gaseous distention after some hours and want to vomit. The medicine also made me [to] feel like can't remember thing. [I] always [look] like stupid and can't think. [I] want to do something also difficult [when in this situation]." (Tan, 42)

However, when the researcher asked her whether she told her condition to the doctor, the participant replied that

“I don’t want to complain to the doctor about the medicine. If I told the doctor [I’m feeling] uncomfortable, the doctor will increase my medicine. So, I don’t want to complain to the doctor. Many people also told me that not to complain to the doctor about the discomfort because the doctor doesn’t understand the situation. He just reviews me once after few months. [He] doesn’t understand, I **don’t dare to tell** them.” (Tan, 42)

The participant further explained that

“After I taken medicine, it did not become better, but [became] worst. I told the doctor [about that], but **he doesn’t want to change the medicine for me**. I don’t want to complain to him. Then I [was] quiet. **I don’t want to talk anymore to the doctor.**” (Tan, 42)

The participant also explained that

“**I talked to the staffs** [about that]. I say my eyes will look upward, but they don’t know it will look more upward later. They talk about me and **scold me**. When I can’t explain to them, **I don’t want to talk too much**. [I] tell them but **they don’t understand and scold me**. They scold me every time. [I] don’t want to talk [to them]. Why [I] talk too much [and later] being scolded, [so I] don’t want to talk [anymore to them].” (Tan, 42)

Another participant also stressed the hardship she experienced after taking medicine and described that

“The medicine was given by the doctor of the general hospital. If [I] did not take [the medicine], [I will] **feel very hard**. It was hard after taking [the medicine]. **I feel dizzy like [I’m] dying**. The doctor forced me to take [the medicine] three times [in a day]. Once in the morning, once in the afternoon, and once at night.” (Cheng, 42)

Then the researcher asked the participant that did she told her condition to the doctor, she replied that

“The doctor **didn’t bother me**. He said that I have schizophrenia and [I] need to take the medicine from the general hospital. [I] need to take the medicine prescribed by the psychiatrist. [It is] the medicine for schizophrenia.” (Cheng, 42)

The participants also stressed that

“**He forced me to take it**. He said my schizophrenia is very serious. [I] need to take this medicine, take it and sleep.” (Cheng, 42)

The participant has attempted suicide caused by mental health problem. As described by the participant

“I have **tried to commit suicide** once because of the mental health problems which made me feel so hard.” (Cheng, 42)

Furthermore, the finding showed that the participants also experienced “oppression” such as being forced and scolded by the staffs at the centre. As disclosed by the participants

“Sometimes [the] staff very bad. [They] want to sell something [to us]. [They] **scold** people if [we] didn’t buy. [They] sell the thing very expensive. So [I] say the staff not good.” (Woon, 57)

“I stay at Chalet E. I go to church after staying for some time. I wear a short pant and go [to church]. After that [I was] being **scolded by the staff** [because] like this. [The staffs] said [I] can’t go to church. So, I answer back that time and [they] said [want to] **transfer** me to Chalet D and stay at there.” (Ms. Hoon, 42)

The finding indicated that the participants were found being “ignored” by the medical practitioners about their conditions that caused by the side effect of medication which then

affected their ability to work, to think and daily routines by the bad feelings such as dizziness and short-term memory, as well as their physical health such as the eyes rolling upwards. The participants are paranoid the doctors or psychiatrist will increase the quantity of medicine when expressing their opinions and thus choose not to talk and complain to them. Moreover, the finding indicated that the participants also felt being “oppressed” when talking and getting scolded by the staffs if they complained about their conditions. The participants felt disappointed and thus also chose not to complain or talk to the staff, enduring it themselves, and just following the instruction instead of voicing it out because they feel helpless and afraid of being admitting to the mental hospital.

The medical care system has historically oppressed women, and the relationship with health care providers are also hierarchical and based on patriarchal model, feminist have criticized it and tried to change the existing structural power relations in society (Andrist, 1997). Hence, one of themes in the feminist model of health care practice emphasized the egalitarian provider-patient relationship in health care setting by decreasing physical, social and personal barriers, as well as concentrating on listening to patient’s stories since attentive listening is important in maintaining the equilibrium in the relationship to empower patient, strengthen the patient’s position and allow the clinician to enter the patient’s world (Andrist, 1997).

The finding is concurrent with the study conducted by Low and Lee (2015) in Malaysia who found that the service users have negative experiences with caregivers of a community-based rehabilitation centre such as having less “voice”, have no freedom, felt “oppressed” when talking to the staffs, and absence of listening. However, the finding is inconsistent with the studies conducted in western countries by Johnson et al. (2004) who found that there were staff availability for talking to the services users of the community-

based care services, Gilbert et al. (2010) also found that the community-based care services have less paternalistic staffs and the service users have more freedom, and Osborn et al. (2010) found that the service users in community-based services have less coercion and a “louder” voice.

Although the feminist perspectives emphasized the elimination of oppression of women (Gary, Sigsby, & Campbell, 1998) and the establishment of community-based service was based on human rights and equity principles to prevent illness and reduce stigma (Kalucy, Thomas, & King, 2005), the finding of this study showed that oppression still exist in the current community-based mental health care practice in Malaysia that presented in the form of power relationship which then worsened in other forms such as gender and disabilities. Therefore, health care services issues particularly oppression and the provider-patient relationship should be emphasized to improve women’s health care and health care delivery to women through the women’s voices.

#### **4.3.3 Isolation and Separation**

Low and Lee (2015) point out that some families in Malaysia preferred their mentally ill relatives to be institutionalized in hospital or community-based rehabilitation centre because lack of knowledge, coping skills, and prevalence of stigmatization. Moreover, people with mental health problems have always been regarded as dangerous and violent, unpredictable, and can never be normal, and thus must institutionalise (Malaysian Mental Health Association, 2017). The finding showed that the participants experienced isolation by their family members because their family members not wanting to bring them home and not accepting them, as well as caused by the long distance from the centre to their hometown, and thus staying at the centre. The finding indicated that the participants also experienced

separation with their family members after being admitted and stayed at the centre although they came from the state where the centre was located. The participant claimed that

“[They] **won’t bring me back**. If said [they want to bring me back], these eight years [they will bring me back]. I just [able to] go back during Chinese New Year and festive season.” (Cheng, 42)

“Maybe my sister **doesn’t want to take care** of me, so I can’t go back. I don’t know why I can’t go back. My sister doesn’t allow me to go back.” (Chai, 57)

“My family agree that I stayed here. [They] **don’t want to bring me back**. My family members don’t want to bring me back.” (Lai, 39)

The participants felt sad that they are unable to go to home because their family members unwilling to bring them back.

Another participant who was unaccepted by her family member and thus stayed at the centre stated that

“I don’t know they **can accept me or not**. But, if they accept me, I also can accept them. Just see they want or not. If [they] come to bring me, I will also live with them.” (Tan, 42)

The other participant also mentioned that she was unable to go home because her hometown is very far and thus difficult for her to go home. As recalled by the participant

“I never go home. **My home is very far. [It’s] difficult to go home and [it’s] not that I don’t want to go home**. [It’s] also difficult [for me] to come back here again if [I’m] going back [home]. [So] I stayed at centre and not going back.” (Boon, 63)

The finding also showed that the married participants with children have experienced separation with their children and forced to leave their hometown after residing at the centre



since they came from other states. They have different experiences although both are married and have children. As described by the participant

“My son is 30 years old, my daughter is 25 years old. Two of them are working.” (Hong, 56)

Then the researcher asked the participants did she know that where was her children working, the participant replied that

“They didn’t tell me. I was here and so I don’t know anything.” (Hong, 56)

This showed that the participant is unclear about her children current conditions after being separated with them and stayed at the centre.

However, the other married participant who has two children whose age 13 and 14 years old has a close relationship with them and disclosed that

“If I didn’t go back, I will use hand phone to call my children to talk to them. Then I post something for them. So far, I have given them computer, watch, or give them some money to use during Chinese New Year. Then I [also] have sent RM200 back every month.” (Sim, 44)

The participant worked as a staff at the centre and resided at the centre for about eight years. The participant has talked more about her interaction experiences with her children such as worry about their education and their interaction with others at school. As described by the participant

“Just that I have a job now, they want me to work. My children have gradually grown up. Later [if they want to] go to college or want to learn some new skills also need to use money. My husband didn’t save money, didn’t own a house, and doesn’t have a car, [he] just has a motorbike. But now has money.” (Sim, 44)

The participant also said that she hoped to be discharged from the centre to live with her children later after being separated from them for a long period.

“Later I have matured, have aged, or retired, **I can go back [to live with them]**. I also have money [that time], [I] can buy [a] house, [and] can ask them to come back [to stay with me] to take care with each other or I can look after their children. Now they want to study, then [I] let them go to study.” (Sim, 44)

The findings showed that the participants were isolated and separated with their family members and left their hometown after being admitted and stayed at the centre. Moreover, the single and married participants have different experiences. The single participants experienced isolation by their siblings and parents by leaving them at the centre, while the married participants separated with their children and family members and forced to leave their hometown. This finding is concurrent with the study conducted by Johnson et al. (2004) who found that the respondent in a crisis house in UK whose children must separate with them and stayed with relatives or friends. Due to the separation, the married participants showed different experiences such as one of them keeping a close relationship with her children, while the other participant knew less about her children. Although they separated with their children, they keep in touch with them to maintain their relationship by contacting them or frequent visits by them.

#### **4.3.4 From Buddhism to Christianity**

Religion has played a role in women’s lives in Malaysia which affect their well-being as measured by attending religious services and acting as a moderator or coping strategy to reduce and prevent psychological distress (Noor, 1999). This was showed in the perspectives on the concept of mental health and help-seeking behaviour as discussed in Chapter Two

(pg.18-33). The finding indicated that some participants doubted on their religious belief system and decided to change their religion affiliation to other, from Buddhism to Christianity, which is discovered to be more helpful for their mental health problems after becoming sick and residing in the centre. The participants explained that the “new” religion has helped them for their mental health problems and act as guidance in their life. As described by the participant

“My aunt brings me to baptize and believe in God. I can be self-reliant, can independent, [I’m] quite okay now.” (Tan, 42)

Then the researcher asked the participant about the differences between believing in Christianity and the traditional help, the participant replied that

“My condition becomes worst. It [traditional help] was not help, [it was] totally not [help]. After believed in God, [I] felt relief, [my] mood [become] quite cheerful, and there is peace in heart. I feel that Christianity is the love religion, love is the priority. Because only love, [we] will be loved [by] God and [God] loves people.” (Tan, 42)

The other participant who also have a same experience of changing of religion affiliation and mentioned that

“I was hurt because of 百忍成金 [toleration is precious in English]. So, Jesus saved me. Jesus said that He is the saviour, save you from the pain. So, I like Jesus. The words from Jesus is also good, [it] won’t condemn people. Christianity also cured my illness. Because when I was sick, I still go to church, and read the Bible.” (Sandy, 63)

The participant continued to explain her experiences of being a Buddhist that

“I was tolerant, [and thus] always endure it [something bad]. The heart becomes not good the whole day. [I always] need people to pay back, if

not [I] will get angry to the people, angry [them] in a long period, and [also] keep it in heart. [If] People say bad word [to me and] treat me bad, I [will] feel angry. If [I] can't get pay back when doing good deed, [I will] angry [at] people, hate people, and [thus] my face looks not good.” (Sandy, 63)

There are participants also decided to change their religion affiliation because they have a feeling of relief, peaceful, and love after affiliating with Christianity.

The finding showed that the participants changed their religion affiliation from Buddhism to Christianity after becoming sick when living at the centre mainly because they found that the “new” religion has helped them for their mental health problems and as a guidance for their lives. Moreover, the finding indicated that the participants found that the “new” religion can transform their current living condition to a better life. Since as stated in the Malaysia Federal Constitution (2010) under section 11 that “*every person has the right to profess and practice his religion and, to propagate it*”, thus the participants are found to change their religion affiliation. Moreover, according to Noor (1999), religion offers hope, relief, and power and thus helpful in adverse condition. Therefore, the finding showed that the participants decided to change their religion affiliation to help in their mental health problems and as a life guidance during their stay at the centre.

#### **4.3.5 Satisfaction of Staying at the Centre**

The finding showed that the participants are satisfied staying at the centre through their feeling of staying at the centre. The participants have bad feelings when they were first coming to the centre such as dislike, not getting used to it and unfamiliarity, sad, and homesick. After staying at the centre for a period, the participants felt good, okay, and happy because they have friends who are like them, the centre is a good place for people with

mental health problems, as well as felt no worry and stress when staying at the centre. The participants described that

“I feel **homesick** and I want to go home. [I feel] homesick because I [was] first time stayed away from home.” (Koh, 48)

The participant said that she felt okay to stay at the centre because she felt lonely at the centre and the fee is quite expensive.

“**Okay** la... [Just that it] is sometimes [I feel] quite lonely la... Because ah... I am so tired. [And] I didn't notice things ah... [So, I] can's stay here la... [because] this place [is] quite expensive.” (Koh, 48)

The other participants felt sad and depressed when she is first coming to the centre but felt okay after staying at the centre. As mentioned by the participant

“I was very **depressed** that time [first coming to the centre], [and feel] sad, because [I] left my hometown.” (Sim, 44)

“[Staying at the centre] **Okay** la... Just that the residents in the centre, some of them have not yet rehabilitated, and some of them are very lazy. [So] I have to order them to do work.” (Sim, 44)

Another participant felt that she is not getting used to the centre because she felt that many people in the centre and too complicated at her first coming but felt okay after staying at the centre and mentioned that

“[I] Feel that [there is] too many people [here]. [I'm] **Not getting used to** it, [and] not getting used to it, [to] see many people here, [I] feel that many people [at here], [it is] too complicated.” (Hong, 56)

“[I] feel **okay**. It is a big group. Everyone is the same [at the centre], [such as] eating and going out together.” (Hong, 56)

There is participant who felt dislike when first come to the centre but felt that it is nothing after staying at the centre.

“I’m very **dislike** when first come to the centre. I know that [coming to the centre] is not very good. Ah... I don’t want to stay [at the centre], I’m not happy to stay at the centre. I have no idea [since] I have reached and thus stayed at the centre lo...I have no idea [since] I have reached, [I] can’t go back to Terengganu.” (Boon, 63)

“I **have nothing** [after stayed at the centre], [just] like usual. As usual, [it’s] nothing. It is very usual that I’m staying at centre, [I feel] there is nothing. There is nothing [to stay here]. [I have] no worries and no stress.” (Ms. Boon, 63)

There is one participant who dissatisfied to stay at the centre either on this first coming or after staying at the centre. The participant explained that

“[I] feel **unfamiliar** at the first time. [I] know [I come to the centre]. [I] feel like unfamiliar. Just that I’m always not get used to the living at centre because it was so sudden [for me] to come here.” (Tan, 42)

“[I feel] **empty**. [Staying at the centre] Just like [I have] no benefit to survive. [I] lived like normal person. [It’s] like usual [and] normal. I felt [like] I don’t have a home feeling. [I have] **no freedom**.” (Tan, 42)

The finding indicated that the participants have mixed feelings on their first coming to the centre since they must leave their family members and their hometown. The participants were dissatisfied with the environment of the centre since they felt unfamiliar and not getting used to the new environment when they first came to the centre. The participants were slowly adapted to the centres’ environment after staying at the centre for a period. The finding also showed that the participants are satisfied to stay at the centre although some participants want to go home and felt no freedom when staying in the centre.

The finding is concurrent with the studies conducted by Gilbert et al. (2010), Johnson et al. (2004), and Osborn et al. (2010) who found that the community-based services are not only preferred by the service users, the services provided are also valued by the service users.

#### **4.3.6 Preference of Living at Home**

The finding showed that the participants in this study preferred to live at home with family members if they were given the choice. This finding was not found in the selected past studies carried out and reviewed either in western countries or in Malaysia. Although the participants have good experiences and satisfied with the centre, the participants would like to go back to live at home with their family members which is understood through their choices. As mentioned by the participants

**“If I have choice, I want to go home,** [I] don’t want to stay here.” (Ee, 42)

The participant explained that

“It is quite free at home. I’m not used to staying here (the centre), [because it has] so many people. I like [to stay at] my own home. [The] food [here] also not delicious. [Because] they [cook] cheap things [and] sure [it’s] not delicious.” (Ee, 42)

Another participant prefers to stay at home because home is the best.

**“I prefer home** because [it’s] quiet. Here (the centre) is sometimes very busy. Sometimes they [other residents] look violent because they homesick ah... [Or] Maybe something disturbs them they say. Everybody likes to go home, even me. **Home is the best.**” (Koh, 48)

The participant stressed that

“I definitely want to go home one day.” (Koh, 48)

Other participants who also preferred to stay at home and described that

“I don’t like [here]. I **want to go home**, [I] want to go home.” and “[I] feel that stay at home is better [and] is quite good. Furthermore, I’m old [and I] can’t work. [I] feel that stay at home is better and is quite good. Home is better.” (Chai, 57)

“**Home is better**. It is free [for me] to go to the shopping mall when I’m back home. [But] here [I] can’t go out. It’s inconvenient for me, [and I] can’t go out at any time. Home is better. Sometimes [I] can go out quickly to buy something, and here has no use, [I] don’t know need to wait till when, [and] staffs also didn’t bring me out.” (Lai, 38)

“**I don’t want to stay at centre**. I can’t adapt at the centre. [Even though I have] stayed five, six, till ten years, I also can’t adapt [at here]. [I’m] still not happy.” (Tan, 42)

However, there are participants who prefer to stay at the centre than at home. The participants explained that

“Of course, centre [is good]. Because the centre is big [and] got nice scenery. [It is] **better than being at home**.” (Cheng, 42)

The participant further explained that

“[When] I’m at home, [the] home [is] very narrow. [My] younger brother also squeezes at here, [there was] no place for me to stay. The back room has also occupied. Where can I sleep? I [then] answered back [and say that] I want to go back to centre. [I want to] back to centre.” (Cheng, 42)

The participant also stressed that

“Yes. **I’m willing to stay at here. [I] don’t want to go home**.” (Cheng, 42)



Other participant who prefer to stay at the centre because it is unsafe for her to stay alone at home and the centre provide her occupational therapy.

“[I] will do something reckless when feeling lonely and staying alone [at home]. [I will] let the bad people come inside the house, [and] also follow them go out, not bothered by it. [But] Here is not allow [the residents] to do that, [so I] can do some work when free and [it] have incentive. Here (the centre) has occupational therapy, but not at home. This is one good thing here [that] is having occupational therapy. [I] just do plastic bag, do it when free [and] from day to night, [because we] do [it] almost every day. I [also] do candle threading. Sometimes [I] joking, dancing, singing, [and] writing. Like today [the centre] has party, I know how to reside poems, [I] know a little bit, so I volunteering to do it.” (Sandy, 63)

The finding showed that the participants preferred to stay at home because it is more relaxing, warm, and free, while the participants preferred to stay at the centre because it has therapy and friends. Although the centre is a new environment for the participants, they need to take some time to adapt themselves in the new environment. Though they have adapted to the centres' environment, the centre is not their home and they will have to leave the centre one day after rehabilitated. Therefore, the participants choose to go back home to live with their family members instead of staying at the centre.

#### **4.3.7 Self-Perception**

In this subsection, the perspectives of the participants were understood based on their understanding and perspectives of being an individual with mental health problem. Since some participants have difficulty in understanding the question in perceiving themselves as an individual with mental health problem, the researcher thus changed the questions to explore their discrimination experiences and their views on women position in the family.

## Perception as a Person with Mental Health Problem

Based on their understanding, the finding showed that the participants perceived themselves as a normal person rather than someone with mental health problems. For those who have presented symptoms such as lack of sleep and short temper were recognised as people with mental health problem as understood by the participants. The participants mentioned that

“Oh. [If] **not enough sleep** then [he/she] will **have problem**, [such as] **easy to lose temper**. But it is still okay to be like this, because some people also like this.” (Sim, 44)

“Not every day I think I am very sick. I’m feeling okay. I still okay. I don’t see [that I was sick]. **I don’t remember myself as a mental patient** because people didn’t say something about me. I didn’t say something bad. Because of this, [my] life became much better and not so focused on the mental health problem. **Just we think [we are] like normal people.**” (Koh, 48)

Another participant felt better if she perceived herself as a person without mental health problem. As explained by the participant

“I’m feeling that there is nothing. It is nothing for me [to have mental health problem]. **[I’m] like a normal person**. But sometime when my family meet [someone], when they talk about me, they don’t know how to tell others like relatives, about my mental health problems. They don’t know how to talk like this.” (Hoon, 42)

After that, the researcher asked the participant’s feeling of how she perceived when her family is unable to tell other people about her condition. The participant replied that

“I feel [that] there is no feeling. I thought that it is never mind telling others to have mental stress. Sometimes it might help others when saying it out.”  
(Hoon, 42)

The other participant perceived herself as a healthy person because she has no boyfriend. The participant believed that a person who suffered from mental health problem because of the unjustifiable relationship. The participant mentioned that

“**I am healthy.** I don’t have boyfriend. I feel I’m very healthy. If have boyfriend, he will hurt people. I don’t have [boyfriend].” (Hong, 56)

The participant also further explained that

“[We] need to be confident, trust ourselves, constraint ourselves. Because a person needs to be self-reliant, need to have a healthy body. If not healthy, [then] maybe have too many boyfriends. Some of them **suffered from mental health problems because of having too many boyfriends.** So, don’t have many boyfriends, should give up boyfriend, and can’t have unjustifiable man and woman relationship.” (Hong, 56)

However, one participant felt that she was a person with mental health problem. As described by the participant

“Aiyo! [I] feel that I was [a] mental health patient. I...I... **I am mad person.** I was mad person...I have mental health problems.” (Cheng, 42)

The finding indicated that the participants perceived themselves as a healthy and normal person since they are absent of the symptoms as mentioned in Chapter Two (refer to Table 2.1, pg.16) such as insomnia, short temper, violent behaviour like beating, and unjustifiable relationship.

## Discrimination Experiences

The finding indicated that the participants faced less experienced discrimination or being looked down by their family members and colleagues. This finding is inconsistent with the argument of Lee et al. (2005), Peterson et al. (2006), Tuti et al. (2009), and Hanafiah and Bortel that family, friends, and colleagues were the main perpetrators of discrimination. However, the finding is concurrent with the argument of Razali and Ismail (2014) that the relatives of the patient with mental health problems tended to have better perceptions due to their life experiences and discriminate them less. As responded by the participants

“Although we are people with mental health problems, I was very thankful to God. I still get promoted even though I was sick. I get promoted after 10 years when I was sick and taking medicine. **My boss won’t discriminate me.** My boss value me very much because I work hard, hardworking, and teaching others. Boss didn’t discriminate me. He knows that I was sick. I am still able to work when I’m taking medicine. So, it’s okay.” (Sandy, 63)

“No. **They didn’t look down on me. My mother loves me.** Just that I was sick and what to do.” (Chai, 57)

“Won’t, **won’t discriminate by other people.** The visitors come and play with us. But I can’t talk to them. They start to play when they arrive, then go back after finished. So, I don’t have enough time to talk to them. I want to talk to them, I like to talk to them, but [I] can’t catch up [with them].” (Boon, 63)

“My family member just asked me to take medicine. **Own people won’t look down at me.** [They] just say that I have mental health problem, need to take medicine, and the doctor asked me to take medicine. At centre don’t have [anyone], **nobody will look down on me.** Because I just have this group of friends. This group of friends treat me very good.” (Cheng, 42)

However, the finding showed that the participants have experienced discrimination or looked down by the public in the form of stigmatization, and in employment. This finding is consistent with the argument of Buizza et al. (2007) and Hanafiah and Bortel (2015) who point out that stigmatisation and discrimination usually occur in the forms of labelling, social exclusion, rejection, and in employment. As recalled by the participants

“Yes. [We] sure will be **looked down by people**. People will like this (look down people). Everyone will do like this.” (Lai, 38)

“**Other [people] looked down on me when I was at home last time.** People will talk behind me when I was working. [They said that] stupid her. [They] talk about me. They don’t know that I have mental health problem and say that I was stupid when working, [my] talking [way] also stupid like this.” (Cheng, 42)

The other participant expressed her view on discrimination experiences. As understood by the participant

“I feel that there is probability [to be discriminated]. Because people with mental health problems, most of the time will be **excluded by the people**. **People with mental health problems find it difficult to get a job.** Because the **people outside** most of the time will **look down** [on them]. I know that people with mental health problems at least will be looked down. [Because they are] Not normal. They thought that we are not normal. I know because I have experienced it.” (Tan, 42)

Then the participant explained her experienced of being discriminated that

“When I go to the church, [I found] they (other church members) like those normal, [and] choose the normal one [to do activities]. I have told them I want to serve at the church, [I] want to sing hymns. **Maybe they thought that I have some problem**, [then] maybe will asked me to sing hymns.

But they treat me quite good. [They] have cared about me and prayed for me.” (Tan, 42)

The finding showed that the participants experienced less discrimination and being looked down by their family members and colleagues, but the public have discriminated them particularly in their way of talking, job application, and during church activities due to the stereotype that they are people who have mental health problems. Hence, discrimination has affected self-esteem of the people with mental health problems and thus excluded them from the society. People with mental health problems thus need cope with their mental health problems, as well as the discrimination by the society.

### **Women Position in the Family**

In Malaysian society, the women’s social status of the three main ethnicities (e.g., Malay, Chinese, and Indian) is perceived to be lower than men where the men are always be the head of the household and one step above the women (Noor, 1999). The women’s status in modern Malaysian Chinese communities might closely link to the traditional cultures that so-called patriarchal (Hirschman, 2016). Hence, the tradition of preferring a son is still upheld in most Chinese family in Malaysia because the son is responsible for the fertility regulation (Gupta et al., 2003; Hirschman, 2016), carry the family name, prestige and possessions, and performing religious rituals and burial rites (O’Connell, 1994; Hirschman, 2016). Due to the historical, social and cultural context, women have had to be secondary compared to men within their families during their entire lives (Zhou et al., 2017).

The finding indicated that women is perceived to have a low status in the family because a son is preferred in the family who has a higher position as compared to a daughter and the situation of the daughter became worst when she is suffering mental health problem since the patriarchal family values were one of the factors that lead to poor mental health of

women (Zhou et al., 2017) and individuals with mental health problems are still not readily accepted as valued members of Chinese societies (Hsiao & Riper, 2010; Yip, 2003). As disclosed by the participant

“My father **prefer son**. I feel like this. But I found out that they studied at a university and far **better than me, because I have this illness.**” (Tan, 42)

Then the researcher asked the numbers of siblings the participant has, she answered that

“[Have] four. Three sons and one daughter.” (Tan, 42)

The participant’s father has remarried and thus she has half siblings. She felt that her father preferred her half-brother more than her because they have a higher level of education, but she has mental health problem.

Another participant also said that her male siblings are more preferred by the family member than female. As expressed by the participant

“Last time my father [and] my mother hasn’t [had son], [now] my mother has my younger brother. My father loved me very much [before my younger brother was born]. **Once my younger brother was born, then my father has not loved me like before.**” (Lai, 38)

Moreover, religion and cultural values further influenced the family structure and the position of women by emphasizing the women’s main roles in the family (O’Connell, 1994). Most major religions such as the traditional Christian, Hinduism, Buddhism, Islamic teaching, and Confucianism also perceived women to have secondary position to men (O’Connell, 1994). The finding showed that the participant has a low status in the family related to the teaching of religion. The participant pointed out her view on the women

position according to the Bible teaching. She believed that women have a second position and unable to exceed men as stated in the Bible. As explained by the participant

“We (women), **according to the Bible**, we are the boy that side (rib). [The] first girl is made by the rib bone. Because the God created you guys (women) from Adam’s rib. So, **we can’t exceed the boy.**” (Sandy, 63)

However, this interpretation of the biblical myth has been argued by the modern feminist thinkers to liberate the women’s status and introduced more equality between the two genders (Gomola, 2014).

The finding showed that the participants have perceived themselves as a woman who has a lower position in family as compared to a man and the situation becomes worst when they are suffering from mental health problems since they were not being valued by the family. The finding is consistent with the finding of the study conducted by Zhou et al. (2017) indicated that women were marginalized and were at the bottom of the family hierarchy. The finding also indicated that the participants perceived themselves as having a lower position as compared to men as stated in the Bible (Gen 2: 18-23 in Gomola, 2014), women are made from Adam’s rib, and thus women are unable to surpass men. Furthermore, in the Chinese culture, males are more often being valued than females because the male plays an important role to inherit the family tradition (Gupta et al., 2003). Therefore, women’s social status in society are perceived due to the existing family structure and further reinforced by the religious and cultural values that emphasized on the gender roles which had led the women to experience gender inequality such as being excluded from economic and political activities (Noor, 1999), domestic violence, discrimination, and traditional harmful practices (O’Connell, 1994). Hence, feminists advocate for gender equality in society and concern about the women’s self-actualization, elimination of oppression, and the advancement of



human dignity for all people (Gary, Sigsby, & Campbell, 1998) in society and women's health and health care system.

#### **4.4 Conclusion**

Individuals who presented symptoms such as hearing “voices”, delusions, loneliness and long-term depression, as well as experiencing hot temper and a troubled feeling would be diagnosed with mental health problems such as Schizophrenia, Depression, and Bipolar Disorder respectively based on the medically accepted classification systems (refer to Table 2.1, p. 16). The age onset of the mental health problem is different based on the mental health problems. The findings showed that the participants have been diagnosed with schizophrenia, depression, and bipolar disorder by the psychiatrists based on the presented symptoms as listed in the medically accepted classification systems and the age onset of mental health problems by the participants is concurrent with the classification systems as discussed in Chapter Two (pg, 14-18).

Due to the presented symptoms, an individual would seek different help such as formal or informal help. The findings indicated a pathway of help-seeking of the participants after recognizing their problems that are divided into three different routes. Family members would be the first people who recognise their problems and decided to go seek help. The first route starts when help outside the family was needed and would usually go for informal help such as traditional treatment by the traditional healers which was influenced by the cultural beliefs system that hold by the first people who recognized the problem. When the traditional treatment was deemed ineffective or when problems become serious, the formal help from a psychiatrist or medical professional would be a second choice (Lim, 2015). However, the finding showed that some participants would choose to seek formal help after their presented symptoms and recognised by themselves or family members or being admitted by the police

officer as showed in the second route. Admission to the care centre decided by the family members under recommendation of medical professionals would be the last choice as showed in the first and second route after discharged from the previous health care settings. However, the finding showed that some participants would be sent to the care centre by their family members once recognising their problems as shown in the third route based on several reasons such as for rehabilitation, no caretaker, insufficient amount of beds at hospital, and “violent” behaviour.

After getting admitted and staying at the care centre, individuals diagnosed with mental health problems have different experiences. The findings showed that the participants have positive and negative experiences after living in the centre. The participants indicated that a good relationship is formed with their family members, the other residents and the staffs at the care centre. However, the finding showed that the participants experienced “oppression” by the staffs and the medical practitioners if being scolded by the staffs or ignored by the medical professionals when expressing their side effect caused by the medication. The finding also showed that the participants experienced isolation by their family members because their family members do not want to bring them home, not accepting them, and caused by the long distance from hometown to the centre since some families in Malaysia preferred their mentally ill relatives to be institutionalized in a hospital or community-based rehabilitation centre due to lack of knowledge, coping skills, and prevalence of stigmatization (Low & Lee, 2015), and thus staying at the centre. Moreover, the finding indicated that the participants also experienced separation with their family members after being admitted and stayed at the centre although they came from the state where the centre was located.

Religion has played a role in an individuals' lives especially women in Malaysia which affect their well-being as measured by attending religious services and acting as a moderator or coping strategy to reduce and prevent psychological distress (Noor, 1999). The finding indicated that the participants doubted on their religious belief system and decided to change from Buddhism to Christianity, which is helpful for their mental health problems after becoming sick and residing in the centre. The community-based services are preferred and valued by the service users (Gilburt et al., 2010; Johnson et al., 2004; Osborn et al., 2010). The participants indicated that they have mixed feelings on their first coming to the centre but satisfied to stay at the centre. The finding showed that the participants preferred to live at home with family members if they were given the choice although they have good experiences and are satisfied with the centre. The findings of changing religious affiliation and the preferences of living at home are not found in the selected literature review in other countries and in Malaysia.

In addition, the finding showed that the participants perceived themselves as a normal person rather than a person with mental health problem if they are absent of the symptoms. The finding indicated that the participants faced less experienced discrimination or being looked down by their family members because the relatives of the patient with mental health problems tended to have better perceptions due to their life experiences and discriminate them less (Razali & Ismail, 2014). However, the finding showed that the participants have experienced discrimination or being looked down upon by the public in the form of stigmatization and in employment because they are people who have mental health problems. The finding also showed that the participants perceived themselves as a woman who has a lower position in family even though they have mental health problems as compared to a man based on the Chinese tradition and the teaching of religion. In the Chinese culture and

belief system, males are more often being valued than females because the male plays an important role to inherit the family tradition and thus women were perceived in the second-class position in the family (Gupta et al., 2003).

## **CHAPTER 5**

### **CONCLUSION AND RECOMMENDATIONS**

This first section of this chapter presents the major findings of the study. Then recommendation for future study are discussed in the second section. The third section discusses the implication of this study on the social work practices.

#### **5.1 Major Findings of the Study**

This study aims to explore and answer to the two research questions which have been translated into two objectives. The first objective is to discover the experiences of women with mental health problems leading to admission to the centre. The second objective is to explore the experiences of the women with mental health problems in the care centre. Although no new areas are found in this study, there are two new findings which are not found in the selected literature reviews in Malaysia and in other countries.

The major findings on the experiences leading to admission are: the study found out that there is a common pathway of help-seeking of the participants after presented mental health symptoms and recognised by their family members. The finding indicated that the participants seek informal help first and choose formal help as a second choice which was strongly influenced by the cultural and belief system of the first person who recognised their problems. Admission to the centre is the last choice after being discharged from previous health care settings due to several reasons such as for rehabilitation, no caretaker, and lack of involvement in decision making. The findings showed that lack of involvement in decision making is the main factor that leads the participants to end up being admitted to the centre rather than being care for by their family at home.

In term of the experiences in the care centre, there are several important findings: firstly, a good relationship formed with family members, other residents and the staffs of the centre is important for the participants because it is a form of social support that is needed in their recovery process (Low, Lee & Jacob, 2017). The findings indicated that a good relationship was formed when staying at the centre between the participants and their family members if there is no quarrelling, visited by family, and able to go out and shopping with their family members; with other residents as treating them well, talking to them, and willing to make friends with them; and with the staffs when they were not scolded by the staffs and followed the staffs' instruction. Secondly, oppression still happens in the mental health care system between the service users and the health care providers such as medical professionals and the caregivers. The finding showed that the participants were being "oppressed" by the medical professional by ignoring their voices when complaining about their condition after took the prescribed medication and felt "oppressed" by the staffs when being forced and scolded by the staffs at the centre.

Thirdly, staying at the centre is regarded as a form of stigmatization by isolating and separating the individuals with mental health problems because lack of knowledge, coping skills, and prevalence of stigmatization (Low & Lee, 2015). The findings showed that the participants experienced isolation and separation after admitted and stayed at the centre because their family members do not want to bring them home, not accepting them, and caused by the long distance from hometown to the centre. Moreover, individuals with mental health problems would change their religious affiliation to help cope with their mental health problems. The finding showed that the participants changed their religious affiliation from Buddhism to Christianity when living at the centre because they found that the "new"

religion has helped for their mental health problems and able to act as a guidance for their lives.

In addition, the mental health service users are satisfied to the community-based health care services but preferred to go back home and stayed with family members if they were given the choice. The finding indicated that the participants are satisfied staying at the centre although they have negative experiences such as being “oppressed” and isolated. However, the finding showed that the participants preferred to live at home with family members if they were given the choice. The study also explores the perception of the participants as being a person with mental health problems and found that they perceived themselves as a person without mental health problem because no presented symptoms to live a “normal” life. Due to unfamiliarity of the question, other questions are developed to explore more on the participants’ perspectives. The findings showed that the participants have experienced discrimination in employment and stigmatized by the public, as well as have a secondary position in the family as being a person with mental health problem.

## **5.2 Recommendations for Future Research**

This study has employed the qualitative method with the of purposive sampling to generate an in-depth understanding on the experiences of the women with mental health problems who are staying at a care centre. If future researchers would like to more in-depth of the experiences of people with mental health problems, they can employ qualitative method by using focus group discussion or narration in response to the research objectives. By using qualitative method in their future study, researcher can collect more data which provides a more comprehensive understanding on the experiences of people with mental health problems which go beyond the limitation of individual interview.

Future researchers can research more on the experiences of the women with mental health problems in different health care facilities as the finding of this study reflects only the experiences of the women-only community-based residential care centre. It is essential to examine the experiences of people with mental health problems in other health care facilities in Malaysia as people with mental health problems might be admitted in other health care facilities. Therefore, future researchers can explore the experiences of people with mental health problems in other health care facilities which might be generate different experiences.

Moreover, future study can be conducted with other ethnic groups in different parts of Malaysia in order to know more about the connection between religion and mental health, as well as their help seeking behaviours. As in this study, the participants seek informal help first and choose formal help as their second choice due to the strong influence of cultural belief system. By recruiting different ethnic groups from different parts of Malaysia, it might allow the future researcher to generate more holistic perception on help-seeking to help the help-seeker in deciding which help could be seek first and help to increase the professionals' knowledge and health care services.

In addition, the relationship between stigmatisation and mental health also should be researched by the future researcher because stigmatisation on mental health in different forms still exist in the society and mental health care system. The finding of this study indicated that the participants faced oppression in the mental health care system and discrimination in employment and by the public and thus it is hoped that stigmatisation on mental health can be reduced with more studies done. Furthermore, future study should include the voices of the people with mental health problems to understand their perceptions and empower the people with mental health problems. Finally, I hope that this study would help in future study in mental health field and as a reference for others future research.



### **5.3 Implications to Social Work Practice**

Although the study outcome does not impact directly to the social work practices, there are some lessons can be learned from the findings in relation to the implications to social work practices since social workers are involved in different health care services and played different roles to meet the clients' needs. The finding of this study showed that people with mental health problems especially women are lacked involvement in decision making in receiving health care services and thus end up being admitted to the centre. Moreover, the participants have being "oppressed" by the staffs and medical practitioners.

As from the finding of this study, social workers can become mediator which is a role who helps to resolve conflicts between client systems at one or more levels of the environment while playing a neutral role (Ambrosino et al., 2012). The social workers who worked at the mental hospitals and community-based settings can be the mediator to help the participants to be involved in the decision-making process together with their family members and the medical practitioner in order to work out a better care plan after getting discharged. This is because social workers respect and promote the right to self-determination and right to participation in all aspects of decisions and actions that affect their lives and well-being (International Federation of Social Workers, 2018).

Moreover, the social workers can become mediator between the participants and the medical professional and the staffs. As in the finding of this study, the participants were being "oppressed" by the medical professional and the staffs at the centre. Social workers can help to improve the provider-client relationship by listening or giving voices to the clients because the participants were found being ignored by the service providers when expressing their opinions to reduce the conflicts between the centre staffs and medical professionals with the clients. Social workers promote social justice and thus challenge

discrimination and institutional oppression to engage people to achieve social justice in relation to society and to people whom they work with (International Federation of Social Workers, 2018).

Social workers promote human rights (International Federation of Social Workers, 2018) and thus can become an advocator who fight for the rights and dignity of people in need of help (Ambrosino et al., 2012). As from the finding of this study, social workers can advocate in the mental health laws and policy to bring about change and uphold the human rights of the people with mental health problems particularly on the admission process after knowing the admission experiences of the people with mental health problems to help them to receive proper treatment without ignoring their rights. In addition, social workers worked with people coming from different cultures, ethnic groups and religion. In order to work effectively with the clients, social workers should understand the different cultures and belief systems that are practiced by their clients to avoid any misunderstanding especially in the perception of mental health and help-seeking behaviour besides enhancing their knowledge since social worker respect for diversity (International Federation of Social Workers, 2018).

#### **5.4 Conclusion**

In conclusion, an individual will seek help when he or she presents mental health symptoms such as hearing “voices”, depressed, and have delusions. Family members such as parents, siblings, and children are the first person who recognise the individual’s problem and will make help-seeking decision that is bound by their cultural belief systems regardless of education background. A common help-seeking pathway for the individual with mental health problem is identified where informal help will be the first choice that is strongly influenced by the cultural belief system of the first person who recognised the problem. Formal help will be the second choice if the traditional treatment is ineffective. The

individual with mental health problem will be admitted at least once to the formal health care settings such as general or mental hospital to receive treatment. Admission to the centre is the last choice for the individual with mental health problem after discharging from the previous health care facilities to receive rehabilitation, no caretakers, and limited places in the hospitals. Normally, the individuals with mental health problems are not involved in decision-making process on receiving their health care services and the decision is made by their family members under recommendation of the medical professional have caused them end up being admitted to the centre.

Staying at the centre have helped the individuals with mental health problems to enhance their relationship with family members, as well as forming new and good relationships with other residents and the staffs in the care centre which is a form of social support in their recovery process. However, staying at the centre cause the individuals with mental health problems to experience “oppression” in the mental health care system by the staffs at the centre and medical practitioners, as well as isolation and separation with family members. The individuals with mental health problems will change their religious affiliation, such as from Buddhism to Christianity which is helpful for their mental health problems and able to act as life guidance when staying at the centre since religion offers them hope, relief, and love which would help in adverse condition (Noor, 1999).

Community-based health care facilities are satisfied by the health care service users. However, the health care service users prefer to live at home with family members if they were given the choice. The individuals with mental health problems will perceive themselves as a person without mental health problems to live a “normal” life. Being a person with mental health problem, the individual will face stigmatisation such as discrimination by the public and in employment. As a woman who has mental health problem, she will not value

in the family since she is perceived to have a secondary position in the family that is bounded by the traditional culture and belief system.

Moreover, it can conclude methodologically that using qualitative research approach is one of the important ways to explore the experiences of people with mental health problems. Using the qualitative method in this study, it is able to generate a comprehensive understanding on the experiences of the people with mental health problem as this method relies on the participants' perspectives (Berg, 2004; Creswell, 2014; Padgett, 2017; Stake, 2010) and allowed the researchers to capture the participants' own words, their thoughts, perceptions, feelings and experiences (Liamputtong, 2009). Furthermore, the participants were able to express their thoughts on their experiences before admission to the centre and their experiences at the centre through their voices. They had also expressed their feelings when disclosing their personal experiences. Therefore, this study had generated in-depth understanding on the experiences of the women with mental health problems by using the qualitative method.

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## **APPENDICES**

### **Appendix A: Interview Guide**

#### **Section 1: Socio-demographic background**

Age, marital status, education level, religion affiliation, origin, length of staying, diagnosis

#### **Section 2: Experiences**

1. Journey to the centre
  - Would you like to share with me about your experience of admission to the centre?
  - How do you feel when you first come to the centre? Why?
  - Is this your decision to come to the centre? Why?
2. Experiences before becoming “sick”<sup>15</sup>
  - Would you like to share with me about your experience before becoming “sick”?
  - How is your relationship with your family, your colleagues and your relatives before becoming “sick”?
3. Experiences after becoming “sick”?
  - What help would you seek when you are “sick”? Why?
  - Would you like to share with me about your experience after becoming “sick”?
  - How is your relationship with your family, your colleagues and your relatives after becoming “sick”?
4. Experiences in the centre

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<sup>15</sup> The term “sick” is being used because the women are more likely to use this word instead of suffering from mental illness or mental disorder when I talked to them at the centre before.

- Would you like to share with me about your experience staying at the centre?
- How do you feel staying at the centre?
- What are the differences of staying at the centre and at home?
- How is your relationship with your family, your relatives, the staff/rehab assistances, and the other residents at the centre?

5. Self-perception

- How do you perceive yourselves as a woman with mental health problem?



## **Appendix B: Permission Letter of Data Collection from Researcher**

Yong Phooi Ling  
No.10, Hala Klebang Restu 29,  
Medan Klebang Restu,  
31200 Chemor, Perak.  
014-9403582  
phooi\_ling@hotmail.com

9 January 2017

President  
Perak Society For The Promotion of Mental Health  
Lot 18200, Batu 8, Tambun  
31150 Ulu Kinta, Perak

Dear Sir/Madam

Application for Permission to Interview Related to Research Work for Master of Social Sciences, University Malaysia Sarawak (UNIMAS)

I am a full-time Master of Social Sciences student at the Faculty of Social Sciences, University Malaysia Sarawak. I am writing to you in regard to my research on the topic "Women with Mental Health Problems: A Study at a Care Centre in Perak, Malaysia". I was an intern as a volunteer with the Perak Society for the Promotion of Mental Health in 2015 and the experience left a long-lasting impression on me. I wish to study the experiences of the residents that leading them to admission to centre and their experiences in care centre.

I request you to allow for my visit to the centre and I would like to conduct interviews with some of the residents. All information provided will be treated strictly as confidential and purely for academic purpose.

Thank you for your kind cooperation and contribution.

Yours sincerely,


Yong Phooi Ling  
Postgraduate Student  
University Malaysia Sarawak (UNIMAS)

## Appendix C: Permission Letter of Data Collection from University

**Fakulti Sains Sosial**  
*Faculty of Social Sciences*

UNIMAS/NC-17.02/03-01 Jld. 2 ( 20 )

12 December 2016



www.unimas.my

**TO WHOM IT MAY CONCERN**

Dear Sir/Madam,

**Application For Data Collection Related to Research Work for Master of Social Sciences, University Malaysia Sarawak (UNIMAS)**

Name : Yong Phooi Ling  
Passport Number/I.C : 920227085646  
Student Number : 16020005

We are pleased to inform you that Miss Yong Phooi Ling is a full-time Master of Social Sciences student at the Faculty of Social Sciences, University Malaysia Sarawak. She has registered her candidacy on 15 February 2016 and is expected to complete her study by 14 February 2018. Currently she is doing her research for her Master of Social Sciences. The title of her project is:

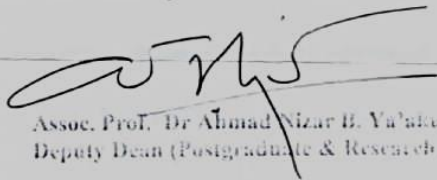
**'Women With Mental Health Problems: A Study At A Care Centre In Perak, Malaysia.'**

**Data Collection Period : From January 2017 to March 2017**


Given these circumstances, we solicit respectfully your cooperation and assistance for Miss Yong Phooi Ling for conducting her impending data collection work at your esteemed institution. All information and data would be used for research purpose only. If you have any queries, please you may contact her academic Supervisor, Assoc. Prof. Dr Ling How Kee (Email: [lhkee@unimas.my](mailto:lhkee@unimas.my)) contact telephone number at +6082 582745 and Co- Supervisor, Dr Hjh. Faizah Bt. Hj. Mas'ud (Email: [mfaziah@unims.my](mailto:mfaziah@unims.my)) contact telephone number at +6082 584117.


Thank you for your kind cooperation and contribution.

Yours sincerely,

  
Assoc. Prof. Dr Ahmad Nizar B. Ya'akub  
Deputy Dean (Postgraduate & Research)

c.c. Dean FSS  
Student File

 MSC-Status



94300 Kota Samarahan, Sarawak, MALAYSIA | Tel + 60 82 581 000 ext 4155/4149/4150 | Fax + 60 82 584 163

## **Appendix D: Research Statement**



### **RESEARCH PROJECT TITLE: Women with Mental Health Problems: A Study at a Care Centre in Perak, Malaysia**

**Supervisor:** Assoc Prof Dr Ling How Kee, and Dr Faizah bt Hj Mas'ud

**Researcher:** Yong Phooi Ling

#### **Introduction to Research Project and Invitation to Participate**

A postgraduate student of University Malaysia Sarawak is conducting a research to explore the experiences of women with mental health problems in a care centre in Perak, Malaysia. It is expected that the challenges, stigmatization and discrimination, and the women's position will be explored through the stories behind the women with mental health problems. We would like to explore your experiences leading to admission to the centre; your experiences before and after becoming "sick", and experiences in the centre.

#### **The objectives of this research project are:**

- To explore the experiences of women with mental health problems leading to admission to the centre
- To explore the experiences of women with mental health problems in care centre

#### **What will be involved**

This research involves you to respond to questions based on your experiences and point of views through a face to face interview. The time taken to complete the questions will base on the time the participant taken to share their stories. The interviews and discussions may be audio-taped with your consent.

#### **Voluntary participation and Confidentiality**

Your participation in this study is fully voluntary. If you give your consent to participate, you can withdraw at any time without any questions. All information, data and materials related to the study will be treated confidentiality. Your personal details and responses will not be disclosed and will be kept confidential and anonymous. We will ensure that all participants will not be identified by their names in any publications or presentations resulting from this study. If we do cite you, only pseudonyms will be used.

#### **Further information about the project**

If you would like further information about the study, please do not hesitate to contact its researcher, Yong Phooi Ling by telephone at 014-9403582 or by email at phoilingyong@gmail.com. Thank you.

Certificate of Consent for Research Project

By signing below, I certify the following:

- I have adequate information about the research project and have read and understand the information provided.
- I have sufficient time to consider participation in this research study.
- I had the opportunity to ask questions and all my questions have been answered satisfactorily.
- I understand that my participation is voluntary and I at any time may withdraw from this study without assigning reason and this will not affect me in any way.
- I understand that all research data will be treated in the strictest confidence.
- I voluntarily agree to participate in this research study.

Name of Participant: \_\_\_\_\_

Interviewer:

Signature:

Date:

## Appendix E: Centre's Approval Letter

 <p><i>Caring by</i></p> <p><i>Caring</i></p>	<p><b>PERAK SOCIETY FOR THE PROMOTION OF MENTAL HEALTH</b>          (Patron: Duli Yang Maha Mulia Paduka Seri Sultan Perak Darul Ridzuan          Sultan Nazrin Muizzuddin Shah Ibni Almarhum Sultan Azlan Muhibbuddin Shah Al-Maghfur-lah)          D.K, D.K.S.A, D.K.A, D.M.N, D.K. ( KELANTAN ), D.K.( SELANGOR ), Ph.D( HARVARD )          Sultan Yang di-Pertuan dan Raja Permaisuri Perak Darul Ridzuan</p>
	<p><b>PUSAT PEMULIHAN JIWA</b> (No. 720 Perak)          LOT 18200, BATU LAPAN, TAMBUN 31150 ULU KINTA, PERAK DARUL RIDZUAN, MALAYSIA.          Tel: 605-533 2167 Tel/Fax: 05-533 5457          E-mail: perakociety_daycarecentre@yahoo.com          Website: - perakocietypmh.com</p>

**Founder:**

Tan Sri Dato' Seri  
 Azlanii Dr.M.Mahadevan  
 PSM,SPMP,DPMP,AMP,AMN,  
 Hon.(Consultant Psychiatrist)

**President Emeritus:**

Dato Dr.M.Majumder  
 DPMP,PMP,AMP,JSM,PHF,FAMM

**Vice-President:**

Dr.Bilbir Kaur a/p Chingara  
 PMP,AMP

**Hon.Secretary:**

Mr.K.Letchimanan  
 PWA,F,ECA,PMP,AMN,BSD,  
 AMP,PPT,PIS,PB

**Hon.Treasurer:**

Dr.Adib Vincent Tung bin Abdullah  
 PMP,AMP,PPA

**Executive Com.Members:**

- i. Puan Putri Norazian bt Megat Abdul Aziz  
PPT,PJK
- ii. Mrs. Vimala Rangam
- iii. Mr.K.Balasubramaniam  
PMP,AMN,PPT,PHF
- iv. Mr.K.N.Chandran  
PPT
- v. Mr.Ong Thiam Kooi
- vi. Madam Molly Kumar
- vii. Mr.R.Udaya Bhanu  
APC,AMP,PJK
- viii. Ms.Carol Cheng Mooi Sim

Ms.Yong Phooi Ling  
 No.10, Hala Klebang Restu 29  
 Medan Klebang Restu  
 31200 Chemor  
 Perak

25/1/2017

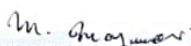
Dear Ms.Yong Phooi Ling,  
**Ref: Application for Permission to Interview PPJ Residents**

With reference to your letter regarding the above matter, kindly be informed that your application has been approved to interview our PPJ residents for your research purpose..

We hope that you will treat all information gathered as ~~with~~ confidential.

Thank you.

Yours sincerely,

  
 .....  
**President**  
 Perak Society For The Promotion Of Mental Health  
 Pusat Pemulihan Jiwa  
 DPMP;PMP;AMP;JSM;PHF,FAMM  
 Lot 18200, Batu Lapan 31150 Ulu Kinta, Perak.  
 Tel: (05)5332167  
 Tel/Fax: (05)5335457

c.c Hon.Secretary

TRUSTEES: Tan Sri Dato' Seri Azlanii Dr.M.Mahadevan & Mr. Beant Singh Jessy



## Appendix F: Centre Brochure

**ELIGIBILITY**

Female clients recommended by psychiatrists may be accepted as day patients or residents, regardless of race and religion.

Male clients may be accepted as Day Patients to learn new skills in the Workshop.

**FEES**

Fees are determined by a sliding scale according to the individual's ability to pay. For further information concerning fees for in-house female residents / day patients, please contact :

**THE SUPERVISOR**  
Perak Society For The Promotion Of Mental Health  
Lot. 18200, Batu Lapan, 31150 Ulu Kinta, Perak Darul Ridzuan, Malaysia.  
Tel : 05-533 2167 or 533 5457  
Fax : 05-533 5457

All donations are tax deductible. Income Tax Exemption Nos. 44 (6) Akta Cukai Pendapatan 1967 - Gazette No. 1762 Dated 23rd May 1974.

Opening of the Cempaka House

Canada Fund Orchid Project

Opening of the Tambun House - Mrs Ella Macdonald

Festive Celebrations

Opening of the Jiwa Fitness Club - Gym

Centre's Art Display at National Art Gallery In KL

Morning Exercises

**PATRON H.R.H. SULTAN OF PERAK**

**CURING BY CARING**

PERAK SOCIETY FOR THE PROMOTION OF MENTAL HEALTH (S.R. No. 730 PERAK)  
Lot. 18200, Batu Lapan, 31150 Ulu Kinta, Perak Darul Ridzuan, Malaysia.  
Tel : 05-533 2167 or 533 5457  
Fax : 05-533 5457  
Email: perakociety\_daycarecentre@yahoo.com  
Website: perakocietypmh.com

**INTRODUCTION**

The society was first established by Tan Sri Dato Seri Dr. M. Mahadevan, PSM., SPMP., DPMP., AMP., AMN., and was formally launched by the Rotary Club, Ipoh under the Patronage of the late D.Y.M.M. Sultan Perak in 1970. The centre was then set up at the Lutheran Clinic in Clark Street, Ipoh. In 1984, it moved to the present premise.

**OBJECTIVES**

The Centre exists to achieve the following objectives :-

- To rehabilitate emotionally disturbed persons and those with psychiatric disorders.
- To secure the co-operation and interest of the public on mental health.
- To promote a better standard of mental health in its social, education and mental aspects.
- To provide facilities to help those who are in a state of mental strain or emotional problems.
- To raise funds for the management of the affairs of the society.
- To promote mental health and awareness among Malaysians.
- To assist those who have been treated for psychosocial disabilities to gain and develop the skills and resources necessary to live in the community.

Stringing Of Plastic Bags

Library

Orchid Project

Glove Packing Activities

Mini Sports

Outings

Clinic Day

Ceramic Painting

Hair Saloon

Stuffing Soft Toys

Cultural Dances

Embroidery Tatting

**SERVICES**

We have a team of dedicated full time staff to provide the following services :-

- Social Rehabilitation.
- Occupational Rehabilitation.
- Counselling Services.
- Medical Supervision by hospital based psychiatrists.
- Administration of prescribed medication by staff.
- Rapid readmission to hospital in the event of relapse.
- 24 hour staff coverage.
- Halal Cuisine.

**FACILITIES**

- Sheltered Workshop
- Recreational Hall
- Residential Chalets
- Library
- Hair Saloon
- Orchid Nursery
- Vegetable Farming
- Ceramic & Handicraft Production
- Fitness Gym
- Community Homes - Tambun & Cempaka
- Day Patients (Male/Female) Intake

## Appendix G: Transcription Key

Keys or symbols	Meaning(s)
Ah, Oh	Affirmative sounds
Ah...	Sound thinking points to speak
La..., Lo...	Auxiliary word means a word that combines with another word in word phrase to help form tense, mood, voice, or condition of the word it combine with
[ ], ( )	Clarifying phrase
...	Thought not completed / Pause last for less than a few second
“ ”	Chinese-language words or idioms
[Pause]	Pause more than a few seconds
[Laugh]	Laughing at something
[cry]	Crying
(interrupted)	Interruptions happen
.	Use a full stop (.) to indicate end of thought
,	Use a comma (,) to indicate continuation of thought
!	Use an exclamation mark to emphasize something
	(Padgett, 2017; Powick & Tilley, 2002; Speer, 2008)